





1  
B  
M  
069  
I  
0  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4322

CERTIFICATE OF DEATH

Reg. Dist. No.

04310

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X WOODSBORO</b>			
c. LENGTH OF STAY IN 1b <b>6 DAYS</b>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM AMOS ARNOLD</b>		First Middle Last		4. DATE OF DEATH <b>APRIL 22 1959</b>		Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 20-1893</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BY DAY</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES ARNOLD</b>				14. MOTHER'S MAIDEN NAME <b>MARY ENGLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-03-1884</b>		17. INFORMANT <b>MARY ARNOLD</b> Address <b>WOODSBORO MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>490X</b> DUE TO <b>Overexposure to radiation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Latent Brachytherapy</b> DUE TO <b>1 Week</b> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr 22 1959</b> to <b>Apr 22 1959</b> , that I last saw the deceased alive on <b>Apr 22 1959</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED <b>9/23</b>			
ACTUAL SIGNATURE <b>J. H. MESSLER</b> M.D.		PHYSICIAN'S NAME (Type) <b>J. H. MESSLER M.D.</b> <b>UNION BRIDGE, MD</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>4/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCKY HILL CEM</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK COUNTY, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cowell &amp; Markley, Woodsboro, Md.</b> ADDRESS				24a. RECEIVED BY REGISTRAR <b>APR 27 1959</b> DATE		24b. REGISTRAR'S SIGNATURE	

ST. JOSEPH-HIGH SCHOOL OF THE SACRAMENT, CHICAGO, ILL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4323

## CERTIFICATE OF DEATH

04311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>7</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FREDERICK MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>LIBERTYTOWN, MD.</b>			
3. NAME OF DECEASED (Type or print) <b>DR. IRA</b> First <b>W.</b> Middle <b>BEALL</b> Last				4. DATE OF DEATH <b>April 16, 1959</b> Month <b>April</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 Feb. 1868</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>91</b> Days <b>91</b> Hours <b>91</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Libertytown, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Washington Beall</b>				14. MOTHER'S MAIDEN NAME <b>Jane Colleberry</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs. Inge Keller</b> Address <b>Libertytown, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>POST-OPERATIVE PROSTATECTOMY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL ARTERIOSCLEROSIS</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>13 April, 1959</b> to <b>16 April, 1959</b> that I last saw the deceased alive on <b>16 April, 1959</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert D. Crouch</b>				ADDRESS (Street, city or town, state) <b>FREDERICK, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT D. CROUCH</b>				DATE SIGNED <b>4/16/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b> ADDRESS <b>Thurmont, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoms</b>	

1931

CERTIFICATE OF DEATH

1931

Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented horizontally but the text is rotated 90 degrees clockwise.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

4346

## CERTIFICATE OF DEATH

04312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X New Midway</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emergency (Chronic) Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALICE</b> First <b>BOWERS</b> Middle <b>BOWERS</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-3-1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Frederick Co., MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Elexius Bowers</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Knipple</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs Helen Bowers Johnstown, Pa</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocardiitis</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO <b>Coronary Hemorrhage</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>4 yrs.</b> <b>7 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. [City or town] (County) (State)		21. I certify that I attended the deceased from <b>July 1957</b> to <b>Apr 4 1959</b> , that I last saw the deceased alive on <b>Apr 4 1959</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>H. F. Kline</b> M.D.		ADDRESS (Street, city or town, state) <b>777 Market St Frederick, Md</b> DATE SIGNED <b>Apr 4 1959</b>	
PHYSICIAN'S NAME (Type) <b>A. F. KLINE</b>		<b>FREDERICK MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Apr. 7, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Haugh's. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Nr Ladiesburg, Fredk. Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont MD</b>	24a. REC'D BY REGISTRAR <b>APR 8 '59</b> DATE
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

ARKANSAS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Name of Deceased [Faint text]		Date of Birth [Faint text]	
Sex [Faint text]		Race [Faint text]	
Date of Death [Faint text]		Place of Death [Faint text]	
Cause of Death [Faint text]		Manner of Death [Faint text]	
Signature of Physician [Faint text]		Signature of Registrar [Faint text]	
Date of Signature [Faint text]		Date of Signature [Faint text]	

Arkansas

Arkansas State Department of Health - Bureau of Vital Statistics

## CERTIFICATE OF DEATH

04313  
Reg. Dist. No.

4347

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville</b>		c. LENGTH OF STAY IN lb <b>38 yrs.</b> <b>X</b> <b>Sabillasville</b> <b>rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>Naylor</b> Last <b>Chenoweth</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1874</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Chenoweth</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Nora Chenoweth</b>		Address <b>Sabillasville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>arteriosclerosis Cardio-Vascular Disease 10 years</b> (c) <b>Old Age 15 years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb</b> , 1958, to <b>April 24</b> , 1959 that I last saw the deceased alive on <b>April 23</b> , 1959, and that death occurred at <b>4:25</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Kieffer</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Blue Ridge Summit, Pa 24 April 59</b>	
PHYSICIAN'S NAME (Type) <b>Robert A. Kieffer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b>		ADDRESS <b>Thurmont, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4324

## CERTIFICATE OF DEATH

04314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
c. LENGTH OF STAY IN 1b <u>DOA</u>				d. STREET ADDRESS <u>1000 N. 1st St.</u>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>NMI</u> Last <u>CLARK</u>				4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 Aug 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret-Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Clark</u>				14. MOTHER'S MAIDEN NAME <u>Annie Dennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-36-4349</u>			
17. INFORMANT <u>Mrs. Emma H. Clark</u> (Same as item #2)				Address <u>(Same as item #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>3 years</u> <u>5 years(?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis, hips, knees, spine</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>October 1957</u> to <u>12 April 1959</u> , that I last saw the deceased alive on <u>12 April 1959</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Walkersville, Md</u> DATE SIGNED <u>4/12/59</u>			
PHYSICIAN'S NAME (Type) <u>James E. Stoner, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u> ADDRESS				24a. REC'D BY REGISTRAR <u>APR 15 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

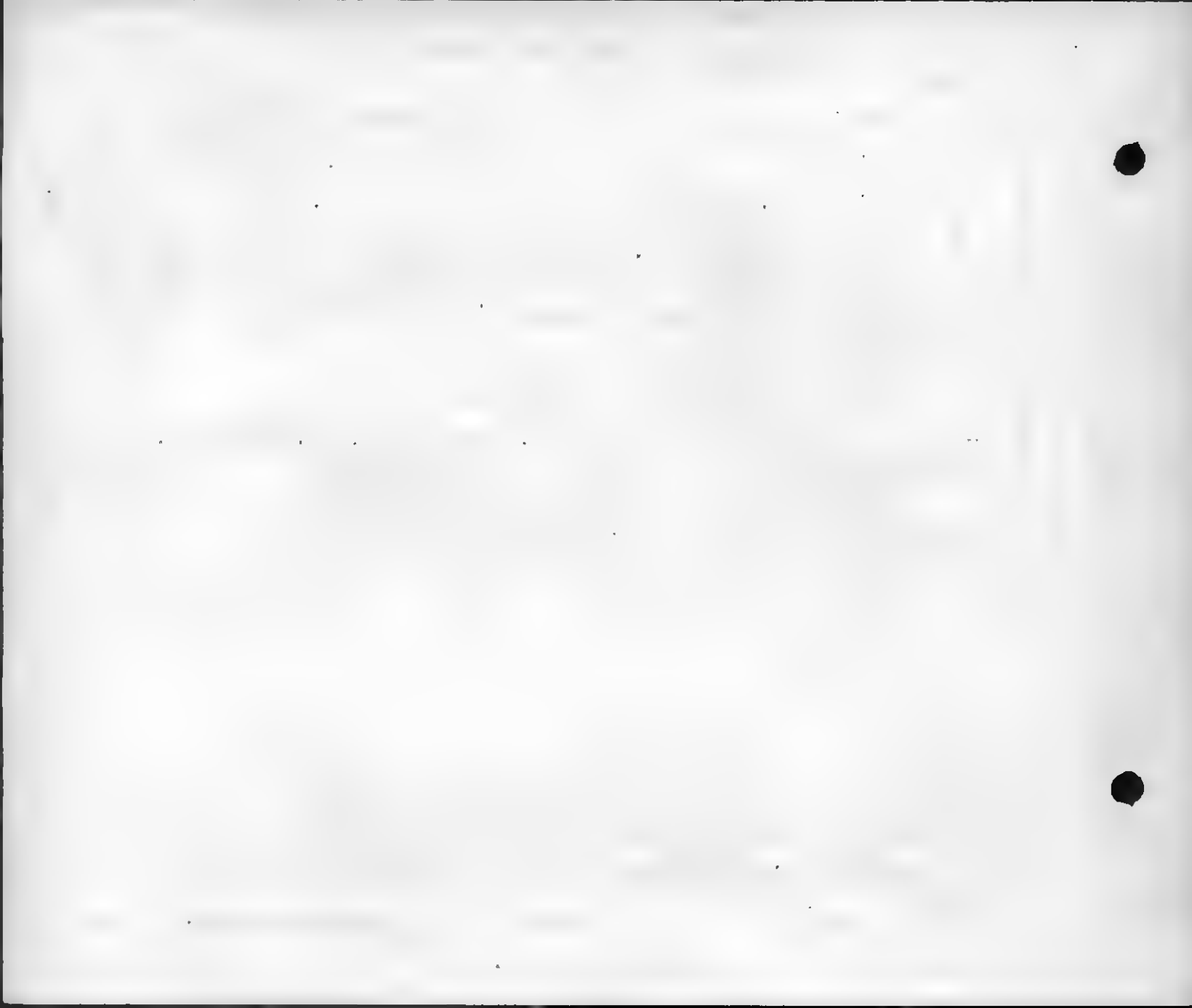
4325

## CERTIFICATE OF DEATH

04315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Mt. Airy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Mem. Hospital</b>		e. STREET ADDRESS <b>RFD # 1, Mt. Airy</b>	
3. NAME OF DECEASED (Type or print) <b>Miss Sarah</b> First <b>B.</b> Middle <b>CLAY</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Nelson Clay</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Purdum</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Jesse Clay, Mt. Airy, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute edema of brain</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of liver</b> DUE TO (c) <b>Malnutrition. Vitamin deficiency</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute pyelonephritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b> <b>10-20 yrs</b> <b>20-30 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 24</b> , 19 <b>56</b> , to <b>Apr. 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 31</b> , 19 <b>59</b> , and that death occurred at <b>6:50</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph L. Michels</b>		ADDRESS (Street, city or town, state) <b>Frederick, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Ralph L. Michels</b>		DATE SIGNED <b>4/1/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		22d. LOCATION (City, town, or county) (State) <b>Kempton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Mohrman</b>		ADDRESS <b>Damascus, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

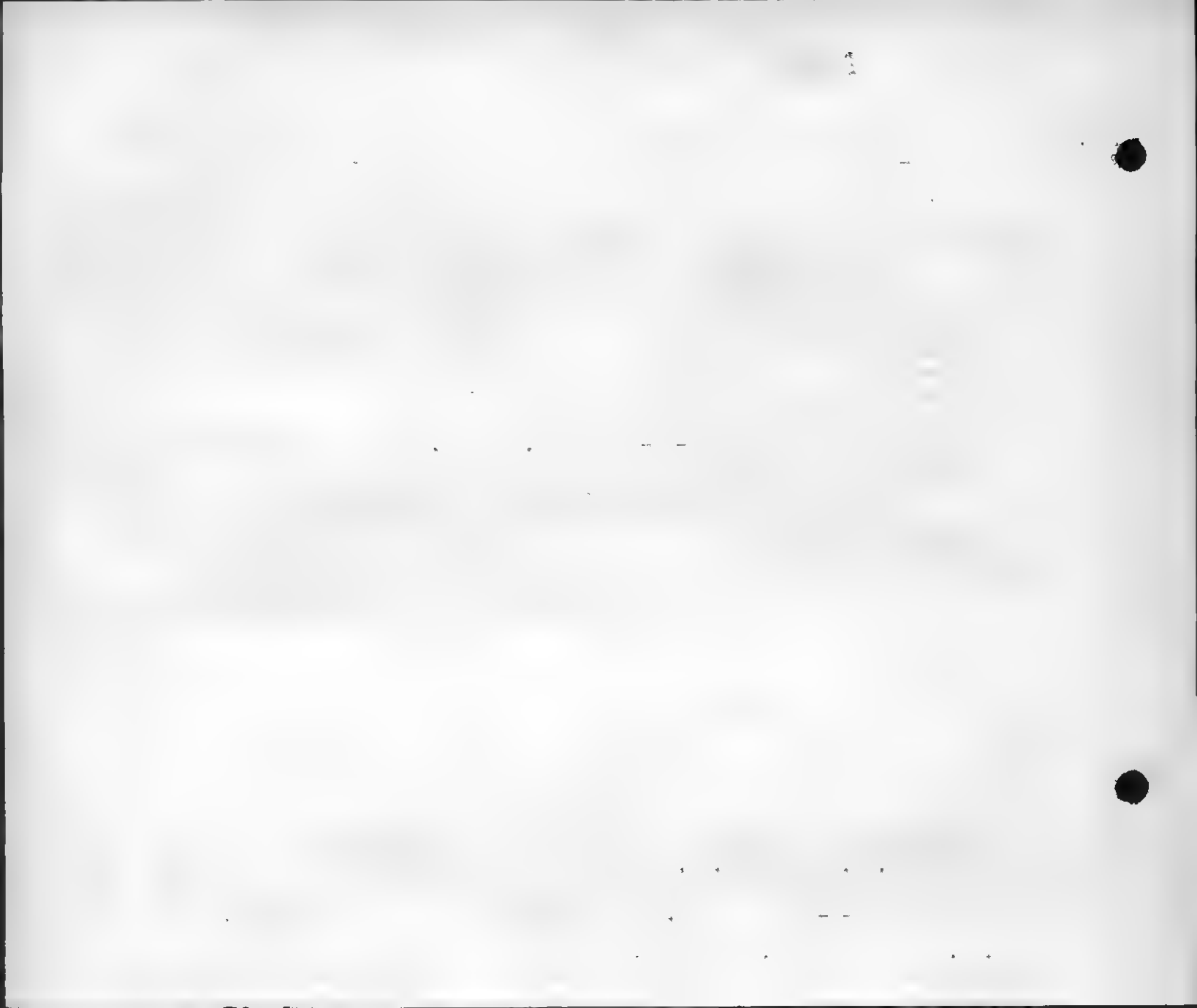
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04316

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown-Rural RD#1</b> c. LENGTH OF STAY IN 1b <b>59 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Point of Rocks</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adamstown-Rural RD#1</b> d. STREET ADDRESS <b>Near Point of Rocks</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>COMPTON</b> Last <b>COMPTON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 Sept 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>4</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Months <b>6</b> Days <b>4</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trunk Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Compher</b>		14. MOTHER'S MAIDEN NAME <b>Lora Sanbower</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>705-07-7654</b>	
17. INFORMANT <b>Mrs. Meda G. Compher</b> (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (c), stating the underlying cause last. <b>DUE TO</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Minutes</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-8-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Point of Rocks, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR <b>APR 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		DATE SIGNED <b>7 April 1959</b>	

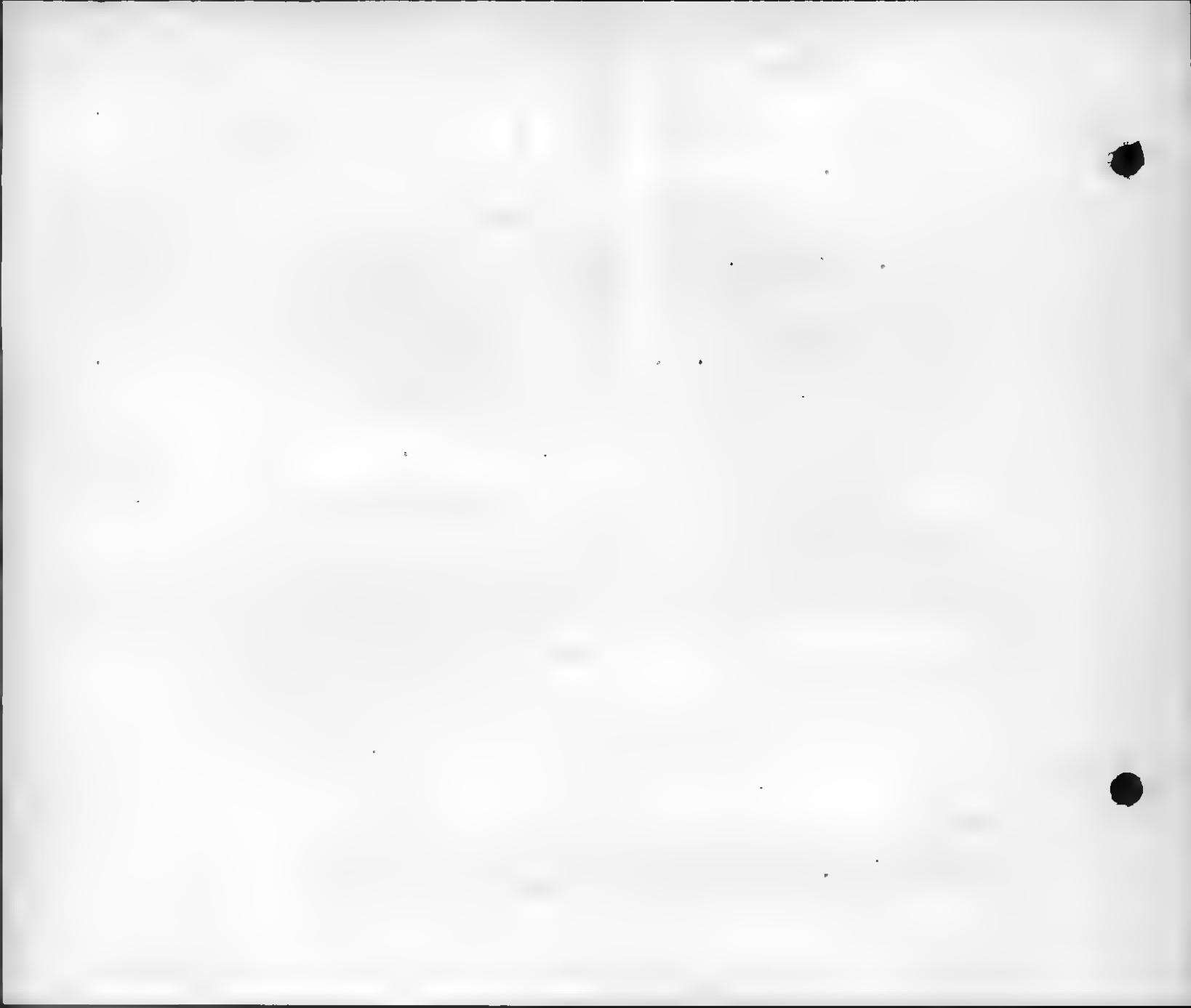


STATE DEPARTMENT OF HEALTH—

## 04317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cullen, Md.</u>		c. LENGTH OF STAY IN 1b <u>9 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cullen State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>J. Raymond COOMES</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/12/ 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering Aid</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Charles S. Coomes</u>	
14. MOTHER'S MAIDEN NAME <u>?? Clifford</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Anna L. Coomes, Landover, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far Advanced Pulmonary Tuberculosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/10/59</u> , 19 <u>59</u> , to <u>4/19/1959</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/18/1959</u> , 19 <u>59</u> , and that death occurred at <u>3:00A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T. F. Vestal</u>		ADDRESS (Street, city or town, state) <u>Cullen, Md.</u> DATE SIGNED <u>4/19/59</u>	
PHYSICIAN'S NAME (Type) <u>T. F. Vestal, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Elchison (Son: Frederick Maryland)</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4326

## CERTIFICATE OF DEATH

04318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>229 East 6th St.</b>		d. STREET ADDRESS <b>229 East 6th St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dorsey</b> Middle <b>Hunter</b> Last <b>Corun</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 17-1921</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>T V- Radio Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dorsey K. Corun</b>		14. MOTHER'S MAIDEN NAME <b>Lola M. Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-14-7814</b>	
17. INFORMANT <b>Mrs. Dorsey H. Corun-229 E. 6th St.-Frederick-</b>		Address <b>MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>7545</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Coronary Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 19, 1951</b> , to <b>April 6, 1959</b> , that I last saw the deceased alive on <b>April 6, 1959</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. T.E. Stone</b>		ADDRESS (Street, city or town, state) <b>4 W. 3rd. St.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. T.E. Stone</b>		DATE SIGNED <b>4-8-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-9-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jefferson Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Driley</b>		ADDRESS <b>Frederick- Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thane</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



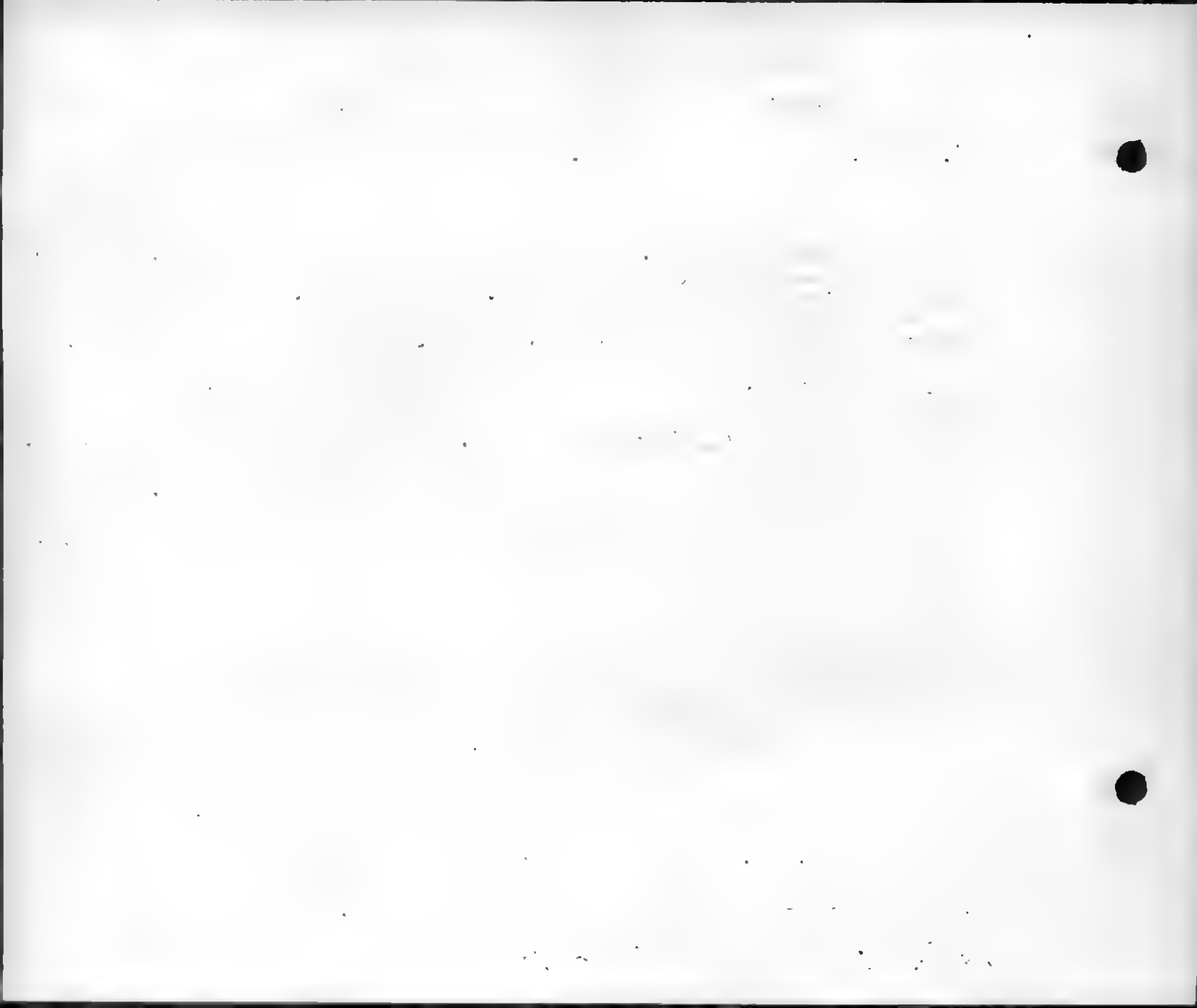
CERTIFICATE OF DEATH

Reg. Dist. No.

4350

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and county) <b>Thurmont</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Home</b>		e. STREET ADDRESS <b>Thurmont</b>	
3. NAME OF DECEASED (Type or print) First <b>Lester</b> Middle <b>L.</b> Last <b>Crouse</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>61</b> Days <b>61</b> Hours <b>61</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done or occupation during working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own business</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elsworth Crouse</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>176-07-8733</b>	
17. INFORMANT <b>Mrs. Louise Crouse</b>		Address <b>Thurmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO <b>2-10 yrs</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>Instant -</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1958</b> , to <b>Feb. 1959</b> , that I last saw the deceased alive on <b>Feb. 19 59</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas A. Love</b> M.D.		ADDRESS (Street, city or town, state) <b>Thurmont, Md.</b> DATE SIGNED <b>4/17/59</b>	
PHYSICIAN'S NAME (Type) <b>Thomas A. Love</b>		<b>Thurmont, Maryland</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b> ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 23 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>243 East Sixth Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>WOODROW</b> Last <b>DEGRANGE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 Jan 1914</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Cab</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles A. DeGrange</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Cline</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>220-10-5000</b>	
17. INFORMANT <b>Mrs. Florence DeGrange (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <input type="checkbox"/> (a), stating the underlying cause lost. (c) <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-21-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 22 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



551

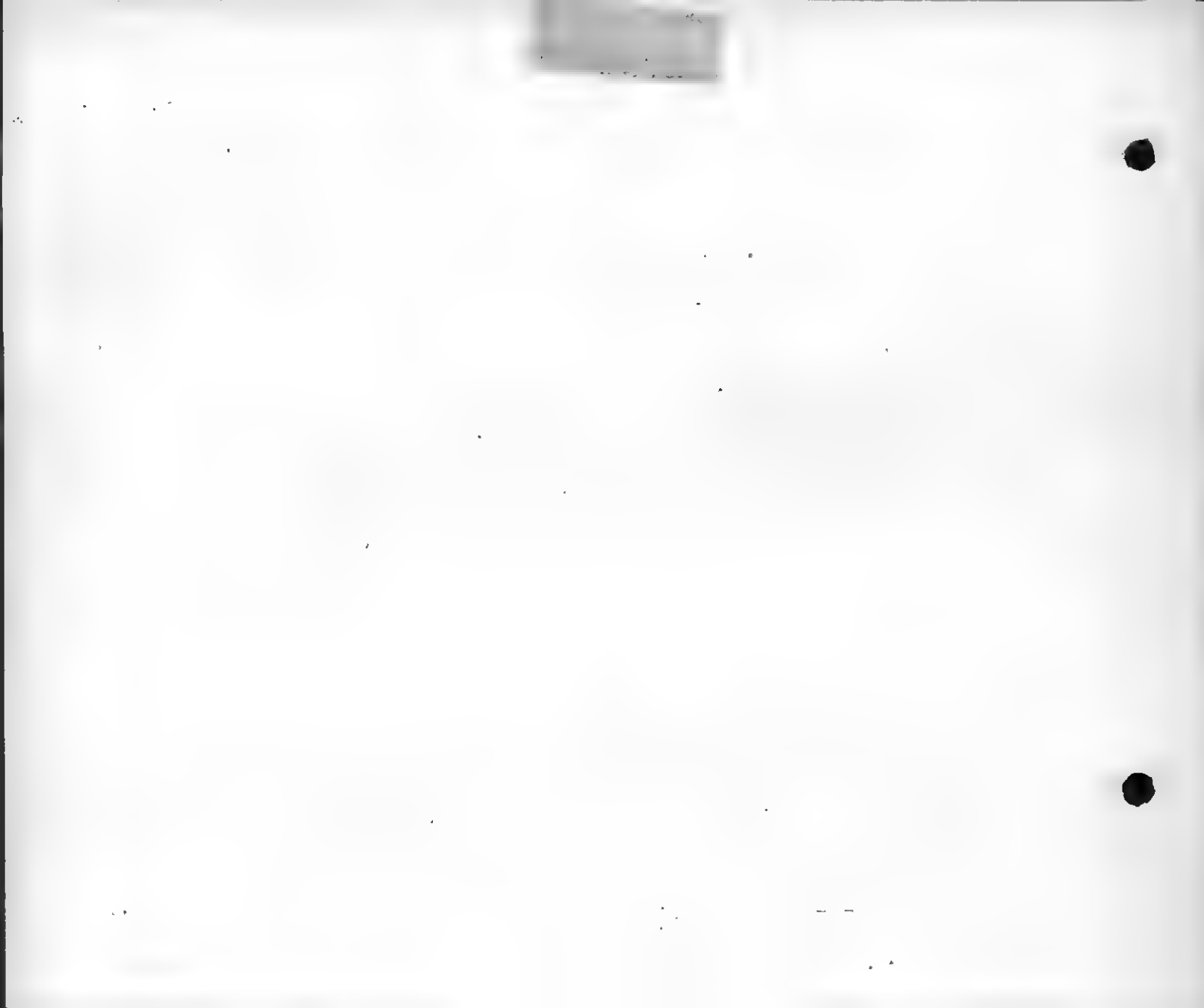
CERTIFICATE OF DEATH

04321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rocky Ridge rural</b>		c. LENGTH OF STAY IN lb <b>25 yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Henry B. Eckenrode</b> First Middle Last		4. DATE OF DEATH <b>April 3</b> Month Day Year <b>19 59</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm work</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Eckenrode</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Cool</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>yes - Mrs Ernest Ridge Thurmont Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>480X</b> DUE TO <b>Broncho pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Influenza like type</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar. 29, 19 59</b> to <b>Apr. 3, 19 59</b> that I last saw the deceased alive on <b>Apr. 1 -</b> , 19 <b>59</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.			
ACTUAL DEATH PLACE <b>James K. Gray</b> M.D.		ADDRESS (Street, City or town, state) <b>Thurmont Md</b> DATE SIGNED <b>Apr. 4 59</b>	
PHYSICIAN'S NAME (Type) <b>James K. Gray</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-5-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CHURCH of BREATHERS CEM</b>	22d. LOCATION (City, town, or county) (State) <b>Rocky Ridge, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b> ADDRESS <b>Thurmont, Md.</b>		24a. REC'D BY REGISTRAR <b>DATA PR 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04322

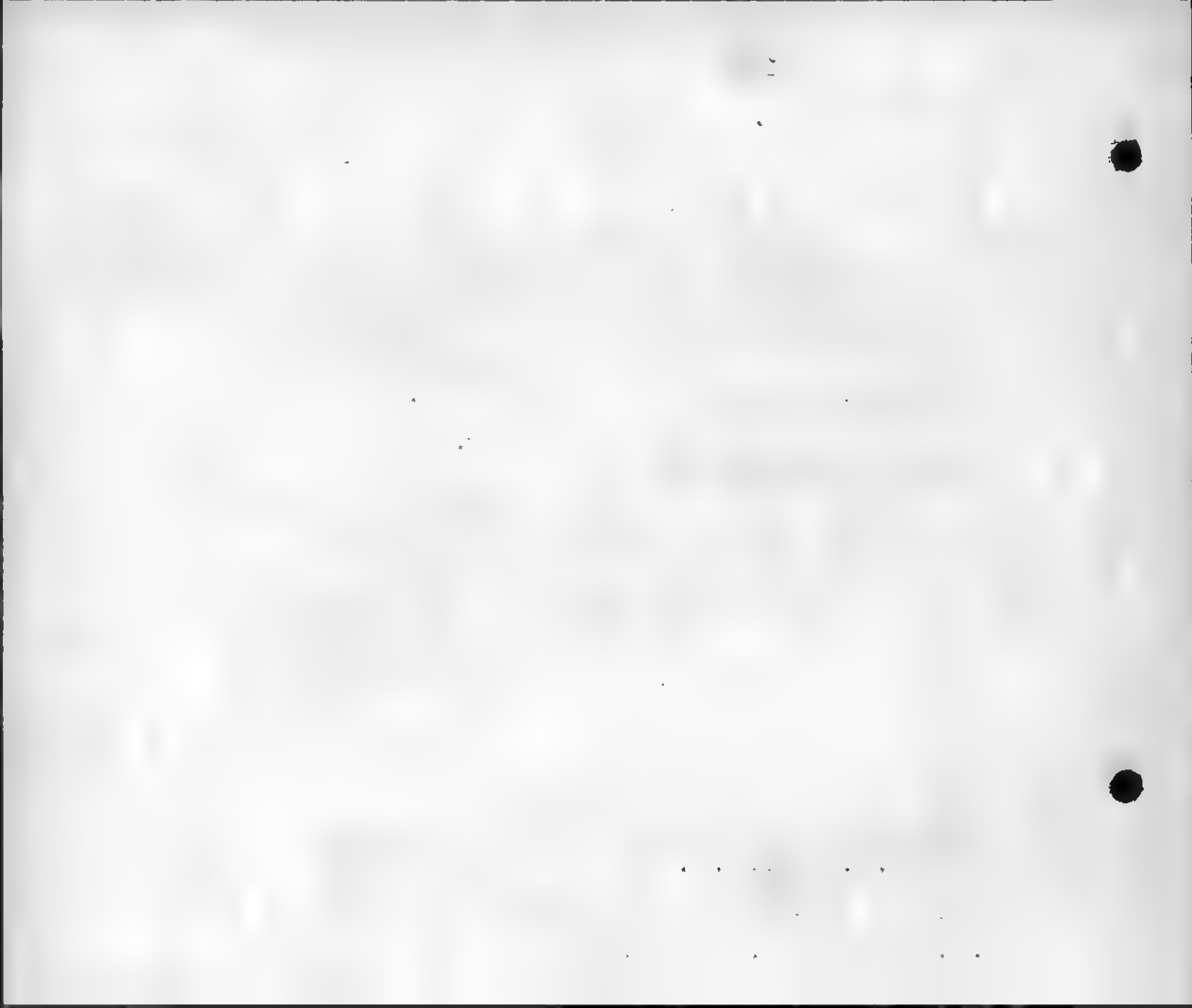
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>6 Hours</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#4</b>			
				f. STREET ADDRESS <b>Feagaville</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LORRAINE</b> Middle <b>LENORA</b> Last <b>FLOHR</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 Feb 1919</b>	
				9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Algie Gregg</b>				14. MOTHER'S MAIDEN NAME <b>Minnie J. Sears</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lester E. Flohr (Same as item #2)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>176 X</b> DUE TO <b>gun shot wound into brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>5 1/2 times</b> (b) <b>brain</b> (c) <b>5 1/2 times</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 times</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self-inflicted 22 Cal. rifle</b>			
20c. TIME OF INJURY Month, Day, Year <b>4/28/59</b> Hour <b>3:30</b> a. m. <b>P. M.</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Feagaville</b>			
				20f. (City or town) (County) (State) <b>Frederick Md.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>29 April 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-1-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. &amp; H. H. H.</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4329

## CERTIFICATE OF DEATH

04323

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural ---Mt. Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		d. STREET ADDRESS <u>at Taylorsville</u>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>H</u> Last <u>Franklin</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1925</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas station</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hanson Franklin</u>		14. MOTHER'S MAIDEN NAME <u>Esther Hooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-22-9635</u>	
17. INFORMANT <u>Mrs. Beatrice Franklin, same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia and emphysema</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>etiology undetermined</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4/13</u> , 19 <u>59</u> , to <u>4/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>59</u> , and that death occurred at <u>9:45 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.		ADDRESS (Street, city or town, state) <u>48 E. Church St</u> DATE SIGNED <u>4/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4-17-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Abenezer</u>		22d. LOCATION (City, town, or county) <u>Carroll Co., Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE APR 17 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 2, Film G241, 4/14/59

# CERTIFICATE OF DEATH

04324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonville Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>Since 7-30-50</b>		d. STREET ADDRESS <b>312 Murdoch Rd.</b> <b>16 Fusting Avenue Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maryland Odd Fellows Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>MARY</b> Last <b>GROOM</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 Sept 1870</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years lost birthday) <b>88</b> yrs. IF UNDER 1 YEAR Months Days Hours M.n.
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Christina Zellers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Odd Fellows Home Records (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Endocarditis</b> <b>421.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 Weeks</b> <b>6 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb. 26, 1959</b> to <b>April 6, 1959</b> , that I last saw the deceased alive on <b>April 5, 1959</b> , and that death occurred at <b>6:30A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St.</b> DATE SIGNED <b>7 April 1959</b>			
ACTUAL SIGNATURE <b>William M. Smith, M. D.</b>		PHYSICIAN'S NAME (Type) <b>Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>



**4352**

**CERTIFICATE OF DEATH**

**04325**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Frederick</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u> c. LENGTH OF STAY IN 1b. <u>5 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Walkersville</u> d. STREET ADDRESS <u>—</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>TENNIE</u> Middle <u>GULBRANDSEN</u> Last <u>—</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>16</u> Year <u>1959</u>			
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 29 1888</u>	
<b>9. AGE</b> (In years last birthday) <u>70</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u>		<b>IF UNDER 24 HRS</b> Hours <u>—</u> Min. <u>—</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Mississippi</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Robert A. Cook</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Pierce</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>229-10-8807-B</u>		<b>17. INFORMANT</b> Address <u>Mrs Wm D. Linn, 515 Lee Place, Ind.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Metastatic carcinoma to left side brain</u> DUE TO (c) <u>Adenocarcinoma of sigmoid colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>  <u>1 month</u>  <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>Dec 24</u> , 19 <u>54</u> , to <u>April 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 15</u> , 19 <u>59</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Walkersville, Md</u> DATE SIGNED <u>4/17/59</u> ACTUAL SIGNATURE <u>James S. Stover, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>JAMES E. STOVER, JR</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4/18/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Green Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Frederick Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>G. E. Barton Walkersville, Md.</u>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Orlana S. Hana</u>	
DATE <u>APR 20 1959</u>				DATE <u>APR 20 1959</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4331

## CERTIFICATE OF DEATH

04326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>		d. STREET ADDRESS <u>FARQUHAR ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ruth ANNA Harman</u>		4. DATE OF DEATH Month Day Year <u>April 16 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 5-1899</u>
9. AGE (In years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN HYSER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE BANGHART</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-20-4189</u>	
17. INFORMANT Address <u>ROLAND HARMAN UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>10 yrs +</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/14</u> , 19 <u>59</u> , to <u>4/16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/16</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. <u>4 E Church St</u>		DATE SIGNED <u>4/16/59</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>	22d. LOCATION (City, town, or county) (State) <u>TANEXTOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W D Hartley &amp; Sons Union Bridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton L. Fournes</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4353

## CERTIFICATE OF DEATH

04327

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE <b>Md.</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Burkittsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindabona Convalescent Home</b>				e. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Clarice</b> Last <b>Hemp</b>				4. DATE OF DEATH Month <b>4</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/9/1901</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>tailoring co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Charles E. Hemp</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Flook</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>220-18-1760</b>			
17. INFORMANT <b>Edwin J. Hemp, Hagerstown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442X</b> DUE TO <b>Self-murder Edema</b>							
(b) <b>Cerebral Hemorrhage</b>							
(c) <b>Hypertensive Cardiovascular Disease</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 1/2</b> <b>3 1/2</b> <b>15 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1952</b> to <b>4/17/59</b> , that I last saw the deceased alive on <b>4/16/59</b> , and that death occurred at <b>P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. A. Talbott Brice</b> M.D.				ADDRESS (Street, city or town, state) <b>Jefferson, Md.</b>			
DATE SIGNED <b>4/18/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/20/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Burkittsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Company, Middletown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>E. J. Hager</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

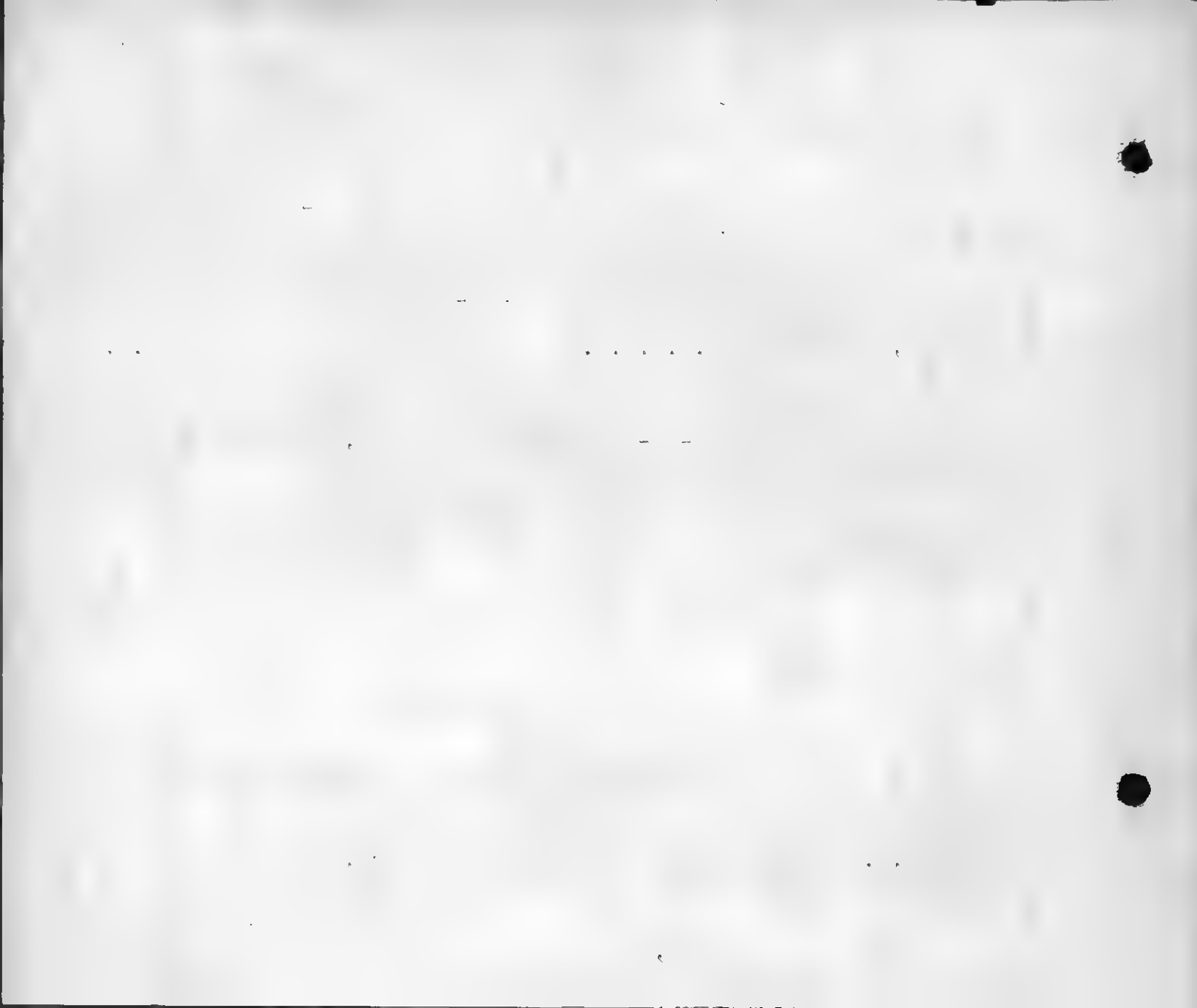
4332

## CERTIFICATE OF DEATH

04328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN TB <b>1 week</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Knoxville</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>			
d. STREET ADDRESS <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Lee</b> Last <b>Hill</b>				4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-27-1907</b>	
9. AGE (In years, last birthday) <b>51</b> yrs		IF UNDER 1 YEAR Months <b>1</b> Days <b>30</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trucker, transfer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B.&amp;O.R.R.Co</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry Hill</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Brasheares</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>705-07-7760</b>		17. INFORMANT <b>Charles Leopold, Knoxville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchiogenic Carcinoma of Lung</b> DUE TO <b>Metastases to Kidney and Spleen</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stethocardia and Congestive Heart Failure</b> (c) <b>Stethocardia and Congestive Heart Failure</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 23, 1959</b> , to <b>April 30, 1959</b> , that I last saw the deceased alive on <b>April 30, 1959</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. A. Pearre</b>				ADDRESS (Street, city or town, state) <b>Frederick, Md.</b> DATE SIGNED <b>4/30/59</b>			
PHYSICIAN'S NAME (Type) <b>A. A. Pearre</b>				<b>Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-2-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reformed</b>		22d. LOCATION (City, town, or county) (State) <b>Knoxville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Jones</b>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 4 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>William E. Knepp</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

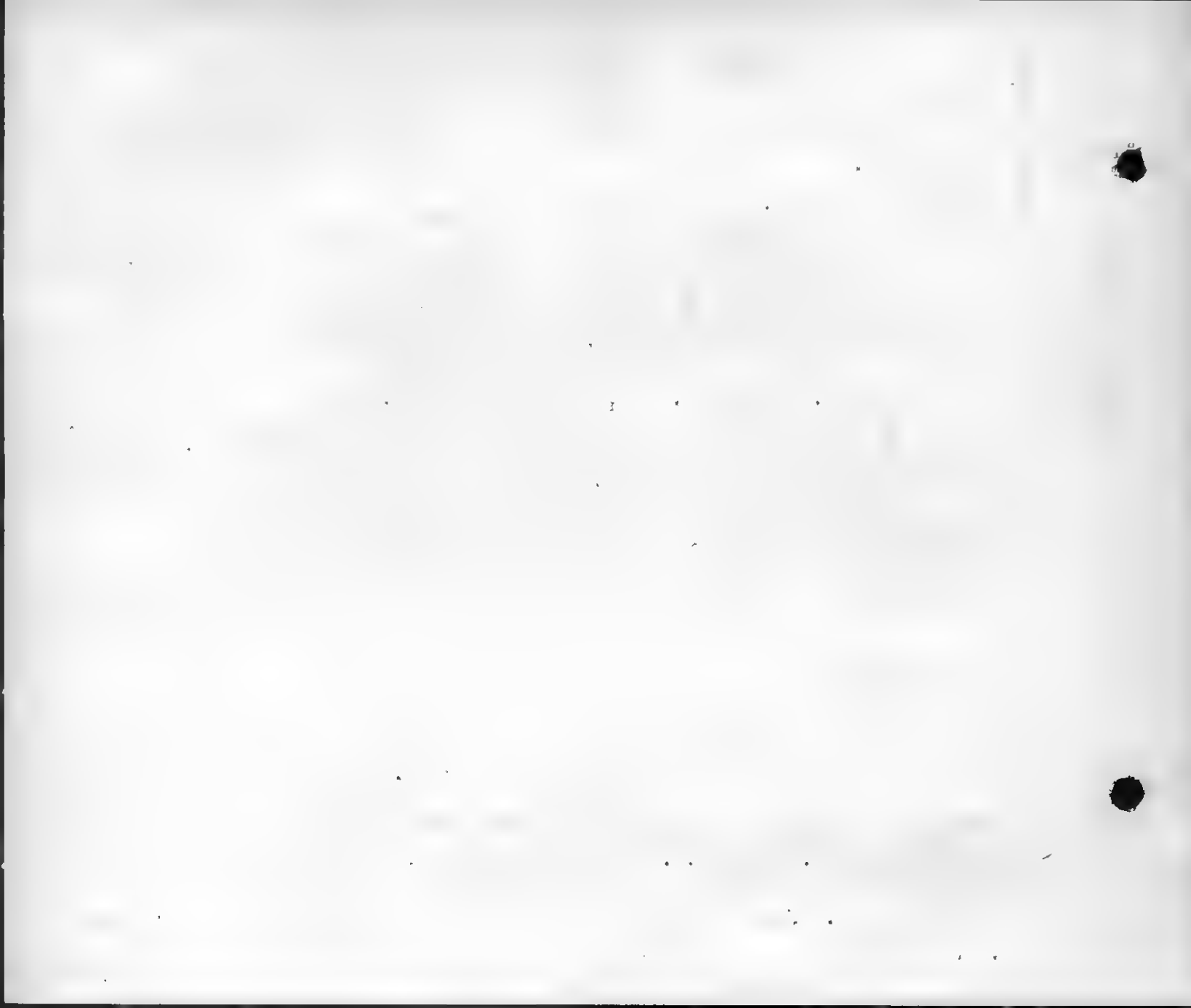
04329

4333

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>100 East Second Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>RODOCK</b> Last <b>HOUCK</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 21, 1888</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George S. Rodock, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary H. Quynn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Miss Regina Elizabeth Bushwaller,</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Diabetes mellitus 2) Acute respiratory infection (Viral)</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1955</b> to <b>4/25</b> 19 <b>59</b> , that I last saw the deceased alive on <b>4/24</b> 19 <b>59</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Church Street</b> DATE SIGNED <b>4/27/1959</b>			
ACTUAL SIGNATURE <b>Henry V. Chase</b> M.D.		PHYSICIAN'S NAME (Type) <b>Henry V. Chase, M.D.</b> <b>Frederick, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4354

## CERTIFICATE OF DEATH

04330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Braddock Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-R.D.#4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Vindabona Convalescent and Rest Home</b>		e. STREET ADDRESS <b>Feagaville</b>	
3. NAME OF DECEASED (Type or print) First <b>FANNIE</b> Middle <b>OLAND</b> Last <b>HOWARD</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1881</b>
9. AGE (In years last birthday) yrs <b>78</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Peter Oland</b>		14. MOTHER'S MAIDEN NAME <b>Malinda Stull</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Ellen H. Cramer--Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterus</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized metastasis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 1944, to <b>April 25</b> , 1959, that I last saw the deceased alive on <b>April 25</b> , 1959, and that death occurred <b>5:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>East Second Street</b> DATE SIGNED <b>4/27/1959</b> ACTUAL SIGNATURE <b>H. L. Fahrney MD.</b> M.D. <b>Frederick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4334

## CERTIFICATE OF DEATH

04331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>50 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 Record Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>POOLE</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Feb 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	9. AGE (In years last birthday) yrs <b>85</b> IF UNDER 1 YEAR: Months <b>18</b> Days <b>19</b> Hours <b>59</b> Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Jones</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Poole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs. Blanche G. Jones (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Prostate with</b> DUE TO <b>Metastases to Bones + Lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 1/2 years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary Anaemia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 1, 1956</b> to <b>April 18, 1959</b> , that I last saw the deceased alive on <b>April 18, 1959</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 E. Church St. Frederick, Md.</b> DATE SIGNED <b>20 Apr 1959</b>			
ACTUAL SIGNATURE <b>A. A. Pearre</b>		M.D. <b>Frederick, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A. A. Pearre, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-21-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>APR 22 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Jones</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>		d. STREET ADDRESS <b>10 Washington Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joy Christine Keller</b>		4. DATE OF DEATH Month Day Year <b>April 16 1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 18, 1946</b>		9. AGE (in years last birthday) <b>12</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank D Keller</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Colliflower</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Hospital records</b>		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized peritonitis</b> <b>545 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Ruptured stomach</b> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Frederick</b>		(County) <b>Md.</b>		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>April 17, 1959</b>			
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		22d. LOCATION (City, town, or county) <b>Frederick</b>		(State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co., Middletown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>APR 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Thomas</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

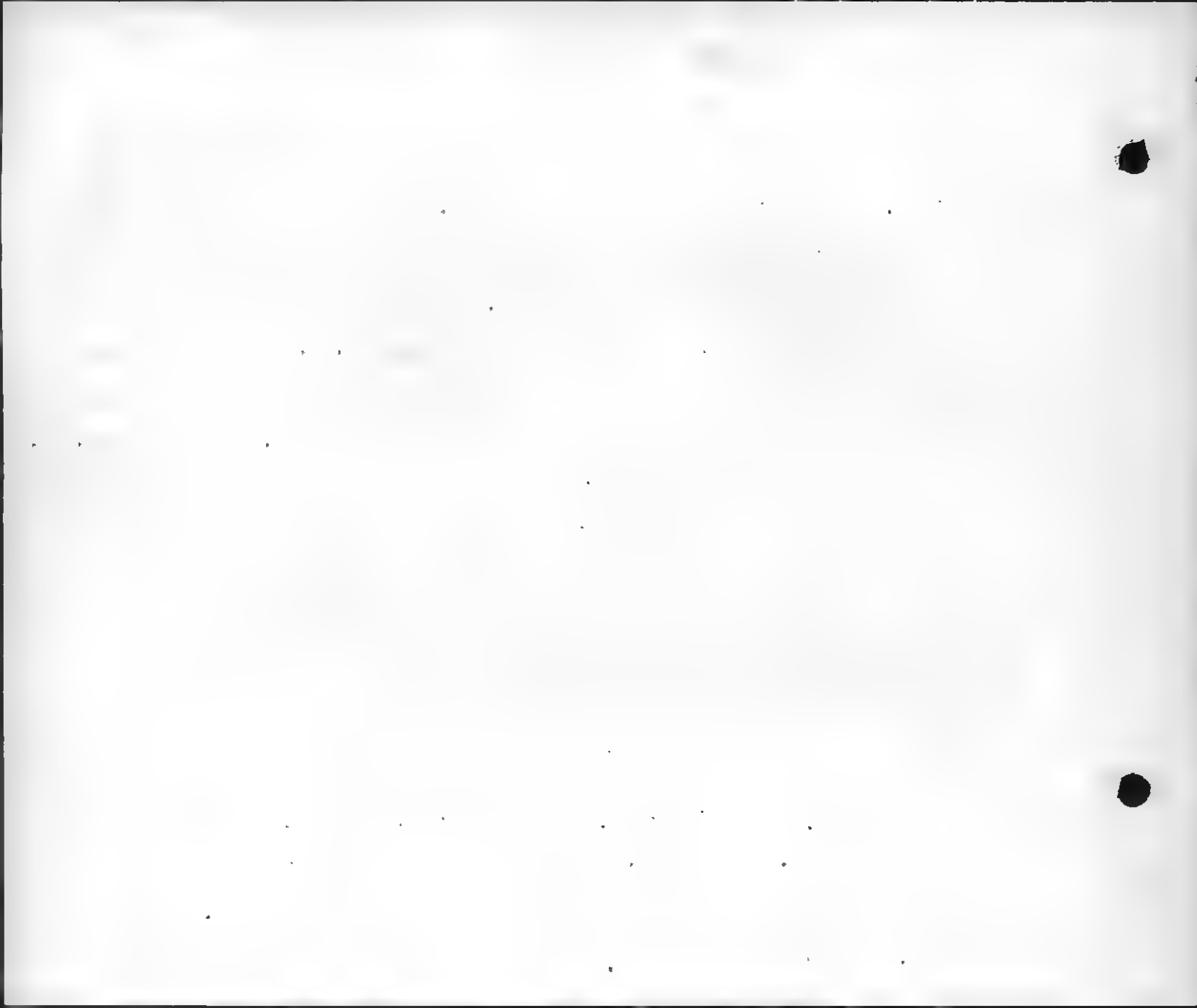
4336

CERTIFICATE OF DEATH

04333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>14 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>225 W. South Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>Henry</b> Last <b>King</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bell Hop - Hotel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick-Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry King</b>		14. MOTHER'S MAIDEN NAME <b>Roberta Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>219-12-1940</b>	
INFORMANT Address <b>Mollie Whalen King-225 W. South St. Fred. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary thrombosis</b> DUE TO (b) <b>Hypertensive CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>15 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1 Aug.</b> , 19 <b>50</b> , to <b>4/10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4/9</b> , 19 <b>59</b> , and that death occurred at <b>11:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. Stoner Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Walkersville, Md.</b> DATE SIGNED <b>4/10/59</b>	
PHYSICIAN'S NAME (Type) <b>James E. Stoner Jr.</b>		<b>Walkersville Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicks III</b>		ADDRESS <b>Frederick, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



4337

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>				c. LENGTH OF STAY IN 1b <b>DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>FREDERICK MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>MIDDLEBURG</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELLIE MARTHA LATE</b>				4. DATE OF DEATH Month Day Year <b>April 9 1959</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 22, 1898</b>		9. AGE (In years last birthday) <b>61</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT L BEALL</b>				14. MOTHER'S MAIDEN NAME <b>ELMA POOLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-22-8650</b>		17. INFORMANT Address <b>MALRICE LATE MIDDLEBURG MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, left lung c</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastases to vertebrae, ribs, pleura</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>10 March 1959</b> , to <b>4/9 1959</b> , that I last saw the deceased alive on <b>4/9 1959</b> , and that death occurred at <b>11:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James E Stoner Jr.</b>				ADDRESS (Street, city or town, state) <b>Walkersville, Ind</b>			
PHYSICIAN'S NAME (Type) <b>JAMES E STONER JR</b>				DATE SIGNED <b>4/9/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT HOPE</b>		22d. LOCATION (City, town, or county) (State) <b>WOODSBORO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DD Hartsburg Union Bridge Md</b>				24a. REC'D BY REGISTRAR <b>DATE APR 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William E. Hartsburg</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

to great ppl, numerous things  
usually, when, either at work

10/10/10 2.

1/1

# Item 22 Film 6241 4-27-59 et

4355

## CERTIFICATE OF DEATH

04335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>V.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cullen</b>				c. LENGTH OF STAY IN 1b <b>One Day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Victor Cullen State Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Paul LIPPEK</b>				4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-29-1886</b>	
9. AGE (in years last birthday) <b>73</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown. Born in Germany.</b>				13. FATHER'S NAME <b>Thomas Lippek</b>			
14. MOTHER'S MAIDEN NAME <b>Marie Paygor</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO <b>218-07-1754</b>				17. INFORMANT <b>Hospital Chart (Patient)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far Advanced Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-21-1959</b> , 19____, to <b>4-22-1959</b> , 19____, that I last saw the deceased alive on <b>April 21</b> , 19 <b>59</b> , and that death occurred at <b>4:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cullen, Md.</b> DATE SIGNED <b>April 22, 1959</b>							
ACTUAL SIGNATURE <b>T. F. Vestal</b>				PHYSICIAN'S NAME (Type) <b>T. F. Vestal, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board of Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Kruger</b>				24a. REC'D BY REGISTRAR DATE <b>APR 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4356

## CERTIFICATE OF DEATH

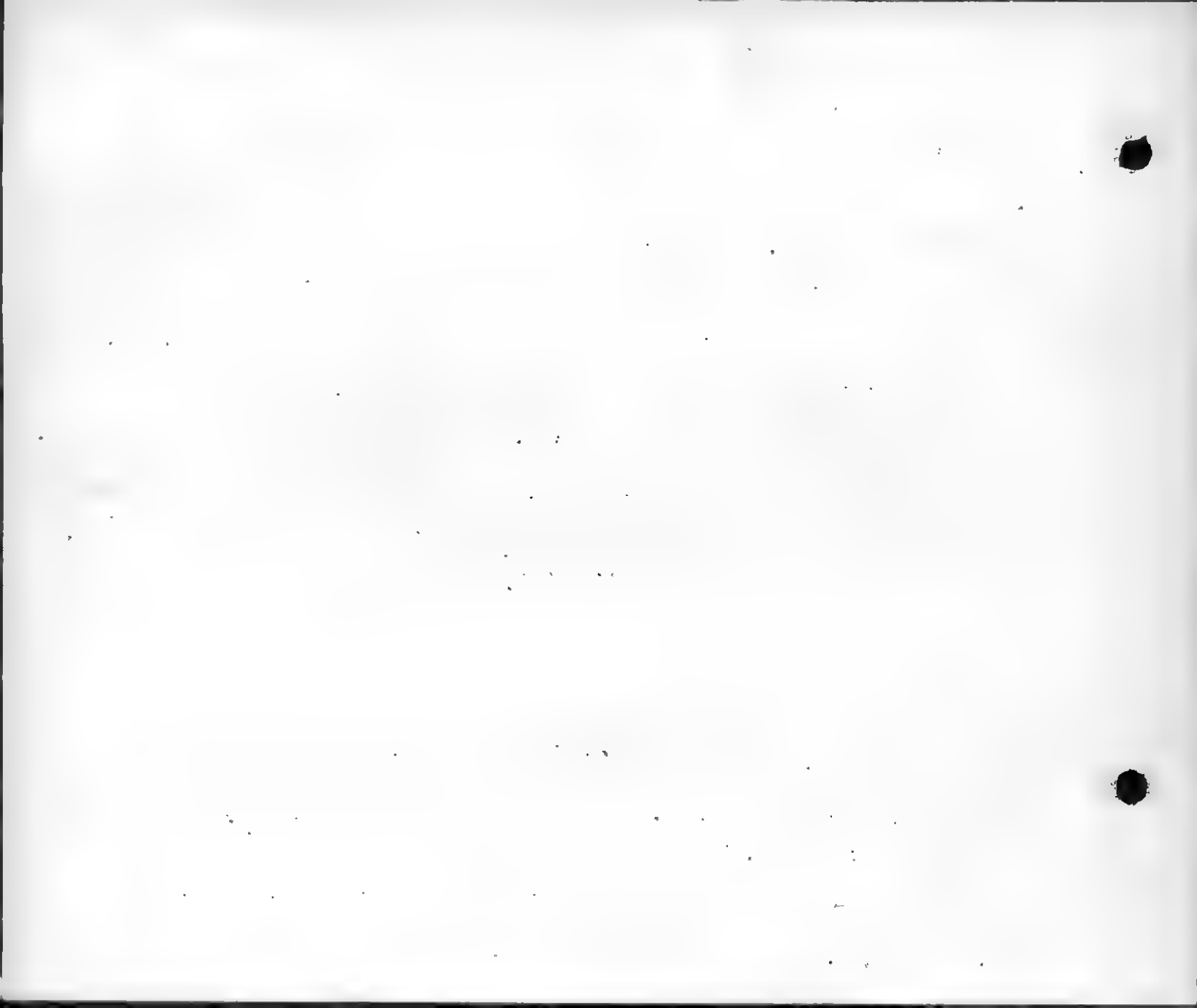
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Home)		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Ida W. Martin First Middle Last		4. DATE OF DEATH April 28 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1885
9. AGE (In years and birthday) 74 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Weddle		14. MOTHER'S MAIDEN NAME Mary Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Donald B. Peters		Address Thurmont, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cerebral Infarct (c) Genl. Dehtitud		INTERVAL BETWEEN ONSET AND DEATH 3 days 7 days - 15 yrs -	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/58, 19, to 4/21/59, that I last saw the deceased alive on 4/20/59, 19, and that death occurred at 6 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Love M.D.		ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED 4/29-59	
PHYSICIAN'S NAME (Type) Thomas A. Love			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-30-59	22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Thurmont, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager		ADDRESS Thurmont, Maryland	
24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbary papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

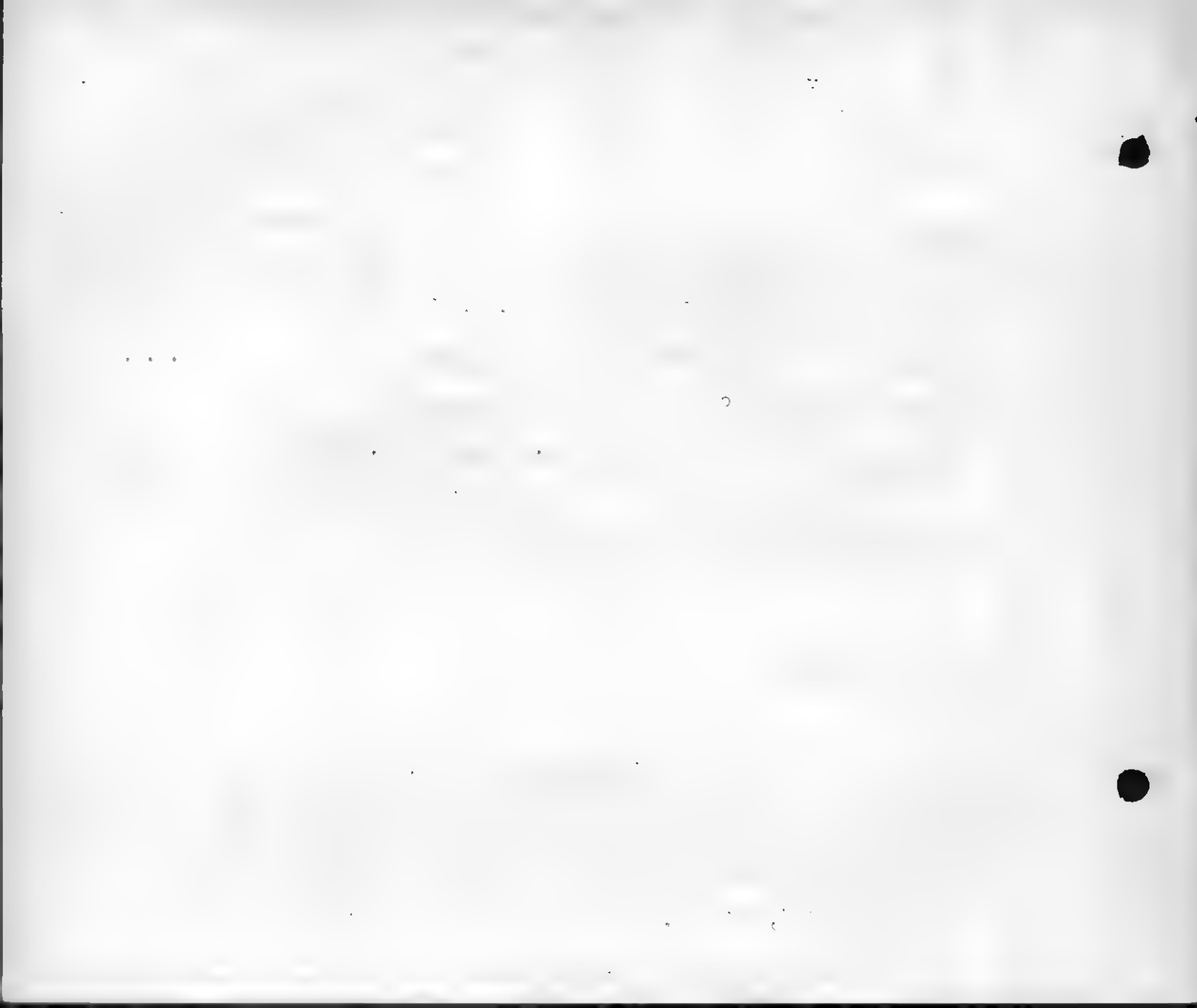
4357

## CERTIFICATE OF DEATH

04337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Emmitsburg</b>		c. LENGTH OF STAY IN 1b <b>Emmitsburg</b>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION		/d. STREET ADDRESS <b>314 E. Main Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Charles</b> Last <b>Mc Graw</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1975</b>
9. AGE (in years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>College Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Francis Charles Me Graw</b>		14. MOTHER'S MAIDEN NAME <b>Susan Virginia Motter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Thomas Eyler, Emmitsburg, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Terminal Hypertensive Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b> <b>several years</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 50</b> to <b>April 2, 19 59</b> , that I last saw the deceased alive on <b>April 2, 19 59</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Emmitsburg, Md</b> DATE SIGNED <b>4-5-59</b> ACTUAL SIGNATURE <b>W R Coals</b> M.D. <b>Emmitsburg, Md</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 6, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> <b>C. O. Fuss &amp; Son</b>		ADDRESS <b>Taneytown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

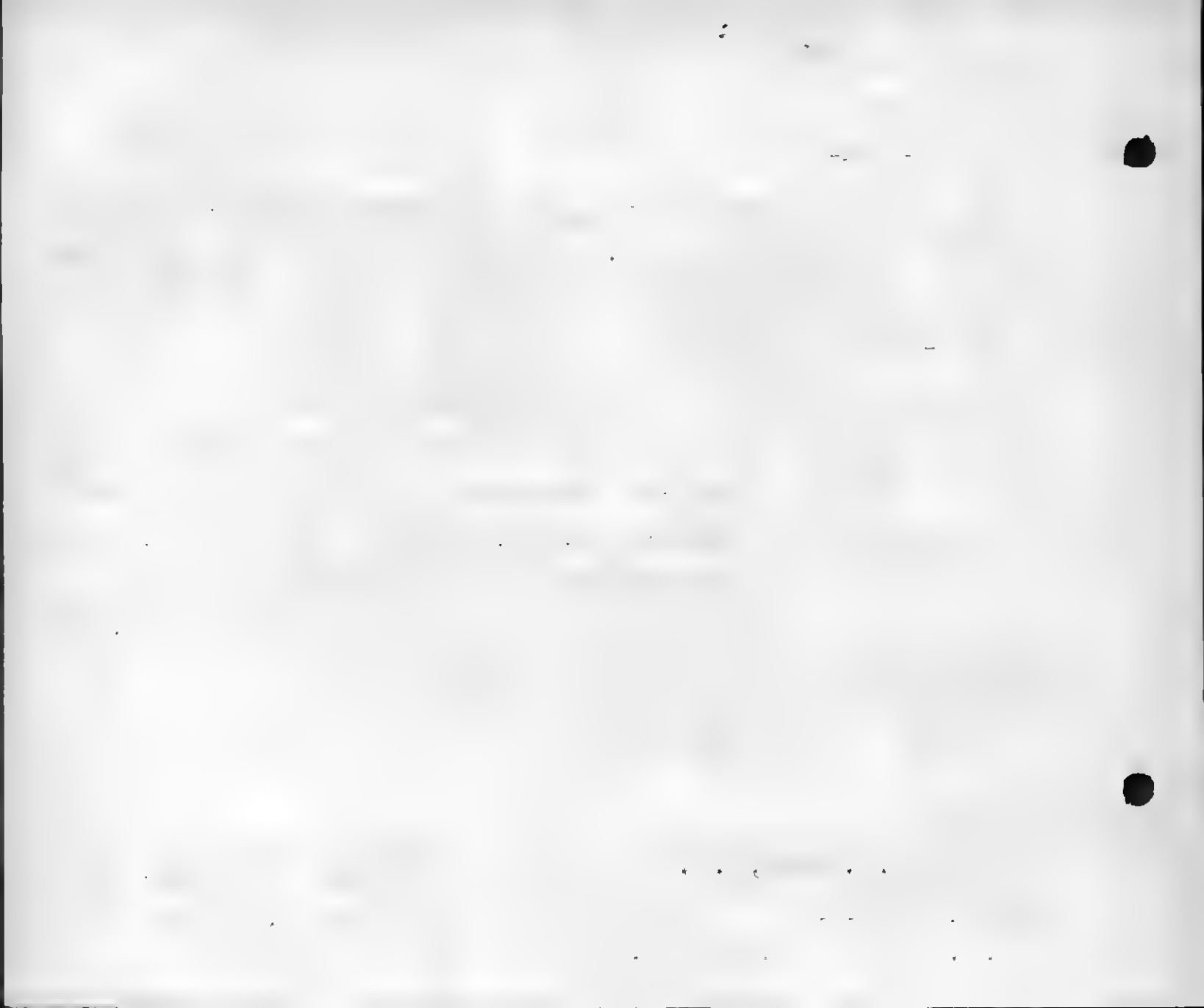


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**4358 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural-RD#7</b>		c. LENGTH OF STAY IN 15 <b>1 Hr &amp; 10 Min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick County Chronic Hospital</b>				d. STREET ADDRESS <b>345 West Patrick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>B.</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 June 1874</b>		9. AGE (in years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b> (Same as item #1) Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Myocardial Infarct &amp; Cirrhosis of Liver</b> DUE TO cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>4 Hours</b>  <b>?</b>  <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>B. O. Thomas</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REG. STRAR <b>APR 10 1959</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Carroll S. Thomas</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04330

Reg. Dist. No.

4359

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural- RD#7</b>			c. LENGTH OF STAY IN 1b <b>13 Hr. &amp; 25 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick County Chronic Hospital</b>				d. STREET ADDRESS <b>345 West Patrick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLAUDE</b> Middle <b>G.</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 1, 1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Upholsterer</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Hospital Records (Same as item #1)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lebar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>B. O. Thomas</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>3 April 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE APR 8 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with item PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Walkersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>PAUL</u> Last <u>MOBERLY</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1911</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brush factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Robert Moberly</u>		14. MOTHER'S MAIDEN NAME <u>Rosa May Benson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-5005</u>	
17. INFORMANT <u>Mrs. Mary Eliza Moberly, Walkersville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial effusion &amp; heart tamponade</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic carcinoma to lungs &amp; pericardium</u> DUE TO (c) <u>Carcinoma head of pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 month</u> <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 Aug</u> 19 <u>58</u> , to <u>26 April</u> 19 <u>59</u> , that I last saw the deceased alive on <u>26 April</u> 19 <u>59</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Walkersville, Md</u> DATE SIGNED <u>4/27/59</u>			
ACTUAL SIGNATURE <u>James E. Stoner Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES E. STONER JR.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. E. Barton</u>		ADDRESS <u>Walkersville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4338

## CERTIFICATE OF DEATH

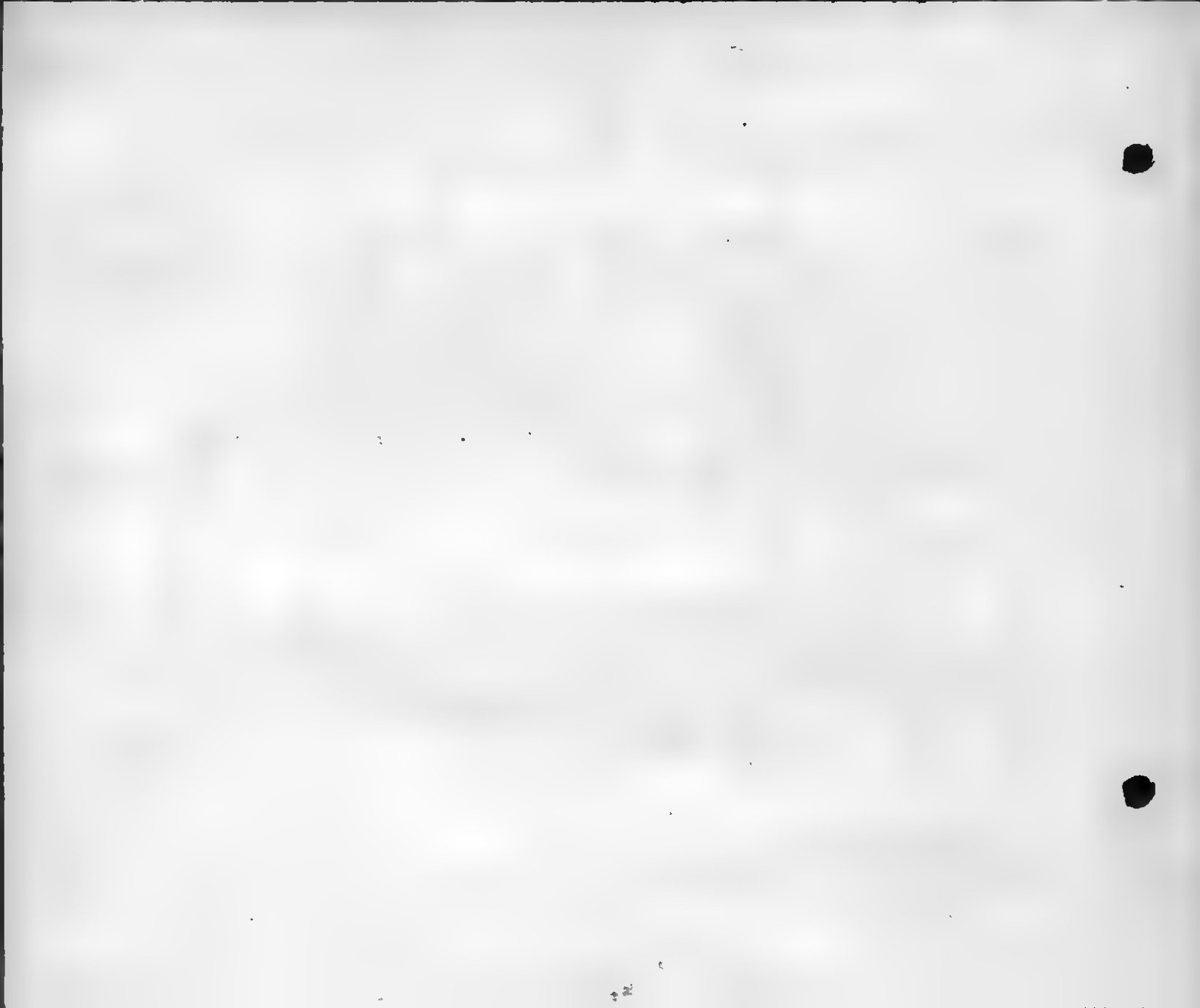
### 04341

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>	
c. LENGTH OF STAY IN IB <u>5 days</u>		d. STREET ADDRESS <u>209 West "B"</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Rebecca Ann Moler</u>		4. DATE OF DEATH <u>April 7 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Grome Zeller</u>		14. MOTHER'S MAIDEN NAME <u>Lauretta Cline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Harry R. Moler, Brunswick, Maryland</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-abdominal carcinoma</u> DUE TO (b) <u>probable carcinoma</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/25/1956</u> to <u>4/7/1959</u> , that I last saw the deceased alive on <u>4/6/1959</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. P. H. P. P. P.</u> M.D.		DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type) <u>Robert H. P. P. P.</u>		<u>Frederick, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. P.</u> ADDRESS <u>Brunswick, Maryland</u>		24a. REC'D BY REGISTRAR <u>APR 9 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
BM 2.57

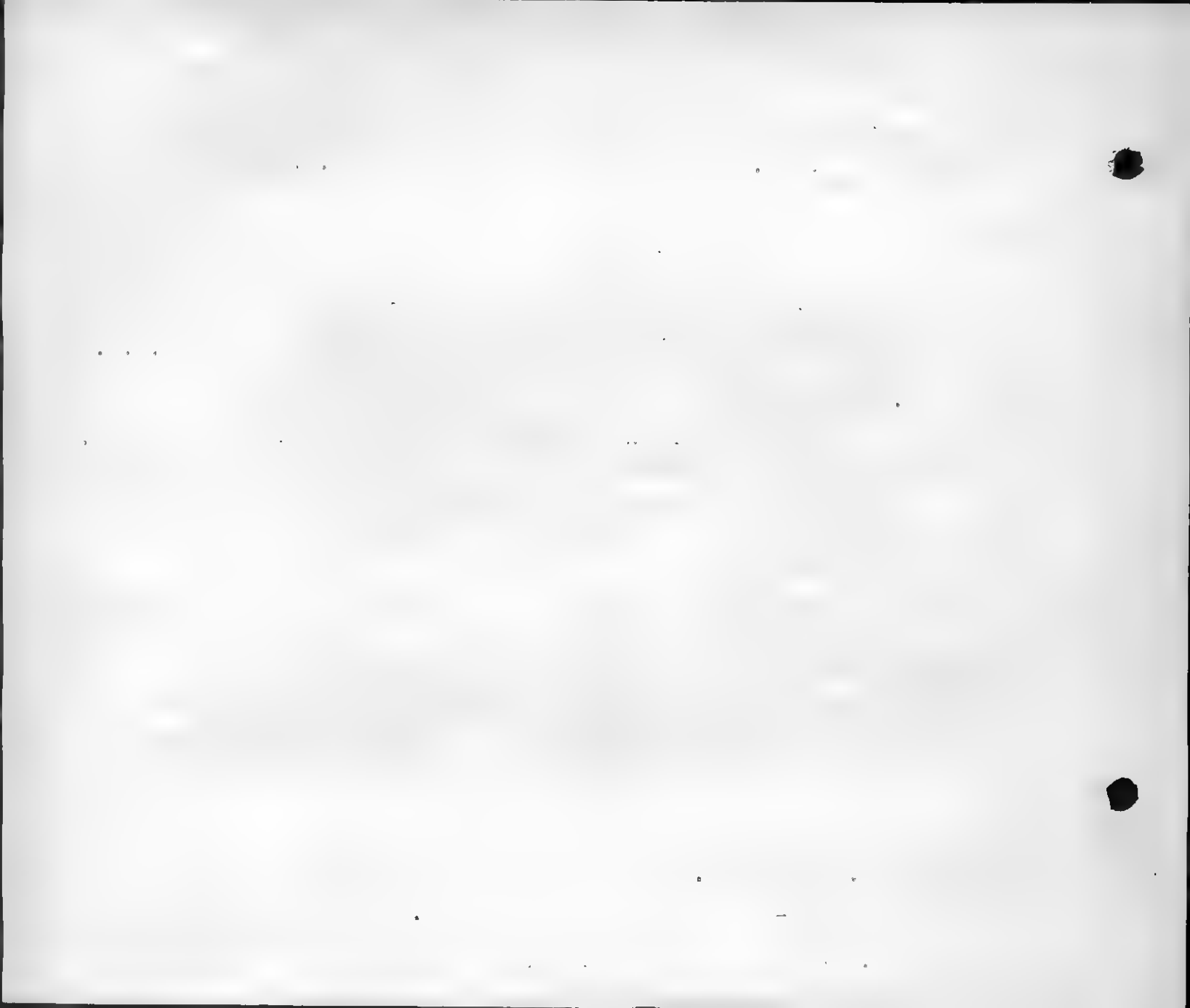
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4361 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Frederick R.F.D.3</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>X Frederick R.F.D.3</b>	
3. NAME OF DECEASED (Type or print) <b>Edward Milton Moringstar</b>		4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 26, 1921</b>
9. AGE (in years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Moringstar</b>		14. MOTHER'S MAIDEN NAME <b>Helen Virginia Toms</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-12-1930</b>	
17. INFORMANT <b>John H Moringstar, Frederick R.F.D.3</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B.O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>April 20, 1959</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>United Brethren Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE APR 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4362

CERTIFICATE OF DEATH

04343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>		c. LENGTH OF STAY IN 1b <u>11 years</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Hill St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Gertrude</u> Last <u>Moxley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1887</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>George W. Shoemaker</u>		14. MOTHER'S MAIDEN NAME <u>Ruth E. Burall</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT <u>Russell Shoemaker, Mt. Airy</u>		Address <u>  </u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> <u>44.2X</u> DUE TO <u>Hypertensive C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1948</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>		
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		
21. I certify that I attended the deceased from <u>1950</u> to <u>April</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 14, 1959</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>W.B. Culwell</u>		ADDRESS (Street, city or town, state) <u>900 So. Main St. Mount Airy, Md.</u>		
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		DATE SIGNED <u>4/20/59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-24-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G.M. Walz</u> ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 23 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04344

Reg. Dist. No.

4363

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#6</b>		c. LENGTH OF STAY IN 1b <b>4 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Bartonsville</b>		d. STREET ADDRESS <b>Bartonsville</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSWELL</b> Middle <b>ARTHUR</b> Last <b>NEWTON</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Aug 1903</b>
9. AGE (In years last birthday) yrs <b>55</b>		10. IF UNDER 1 YEAR: Months <b>13</b> Days <b>13</b> Hours <b>19</b> M n <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Chicago, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Kutz Newton</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Engles</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>354-05-8577</b>	
17. INFORMANT <b>Mrs. Pearl J. Newton</b>		Address <b>(Same as item #1)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary Thrombosis</b> DUE TO <b>430.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b> <b>1 year</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nw</b> , 1958, to <b>13 Apr</b> , 1959, that I last saw the deceased alive on <b>7 Apr</b> , 1959, and that death occurred at <b>12 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4 W. Third St.</b> DATE SIGNED <b>13 April 1959</b>			
ACTUAL SIGNATURE <b>Thomas E. Stone</b> M.D.		DATE SIGNED <b>13 April 1959</b>	
PHYSICIAN'S NAME (Type) <b>Thomas E. Stone, M. D.</b>		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-16-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>APR 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4364

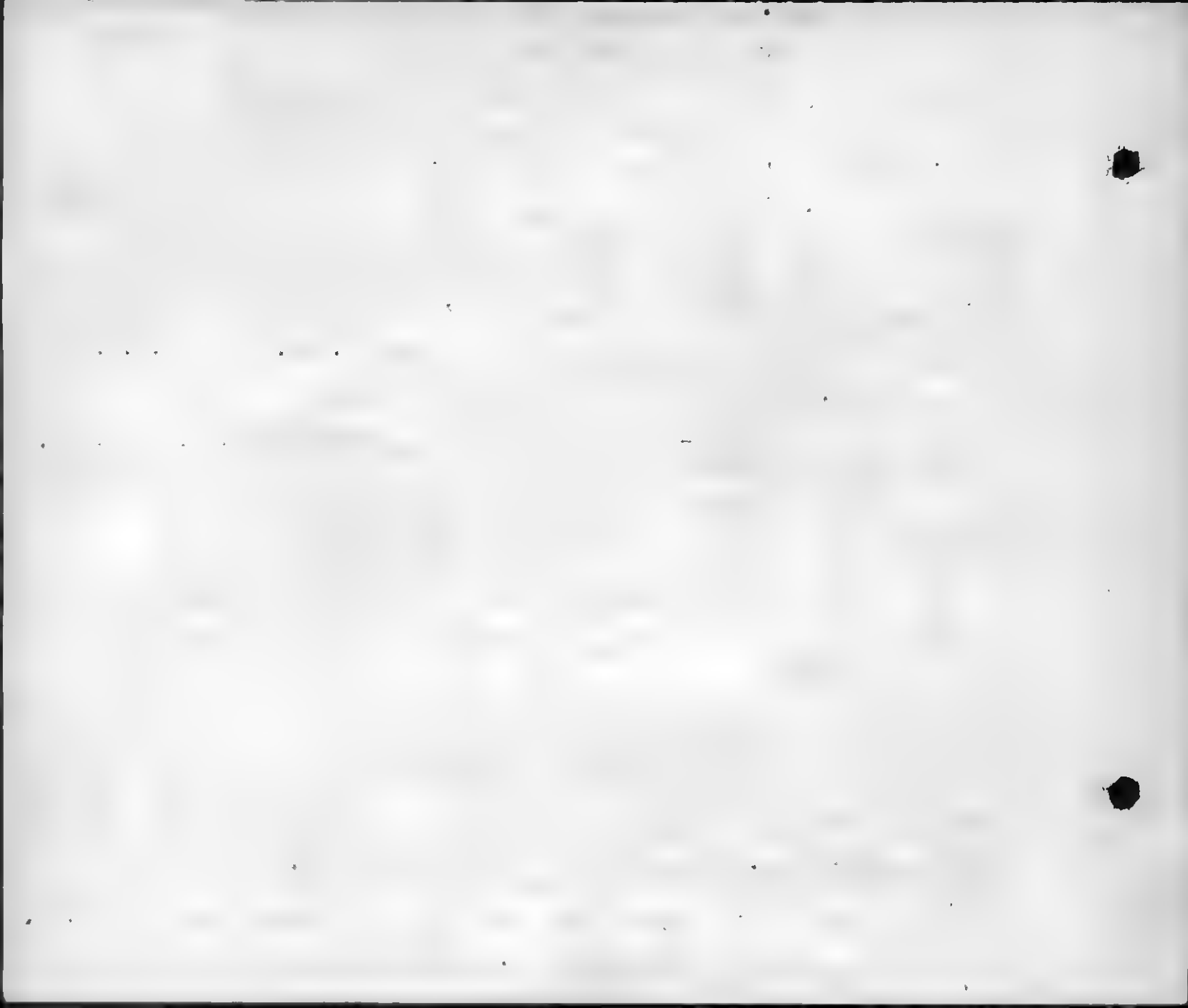
CERTIFICATE OF DEATH

04345  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Emmitsburg,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Emmitsburg,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Willard</b> Last <b>Ohler</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> , Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1907</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b>51</b> Days <b>15</b> Hours <b>15</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garage Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>car</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Ohler</b>		14. MOTHER'S MAIDEN NAME <b>Katie Willard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-9079</b>	
17. INFORMANT <b>Ohler &amp; Ohler</b>		Address <b>Emmitsburg, R.D.#1, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 4 <b>1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 minutes</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of the liver with ascites myocardial degeneration</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>myocardial degeneration</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 27, 1955</b> , to <b>April 15, 1959</b> , that I last saw the deceased alive on <b>April 13, 1959</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles R. Williams</b> M.D.		ADDRESS (Street, city or town, state) <b>Emmitsburg, Md.</b> DATE SIGNED <b>4/15/59</b>	
PHYSICIAN'S NAME (Type) <b>Charles R. Williams</b>		<b>Emmitsburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>April 18, 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>United Brethren</b>	22d. LOCATION (City, town, or county) (State) <b>Thurmont, Frederick Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>		ADDRESS <b>Emmitsburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 MD MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4339

## CERTIFICATE OF DEATH

04346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LIBERTYTOWN RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER VINCENT PITTINGER</b>		4. DATE OF DEATH Month Day Year <b>April 24 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/1879</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB PITTINGER</b>		14. MOTHER'S MAIDEN NAME <b>JULIA HARTSOCK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>JESSE PITTINGER</b>		Address <b>LIBERTYTOWN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Heart failure hemorrhage</b> <b>101X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis &amp; degeneration</b> DUE TO (c) <b>arteriosclerosis &amp; degeneration</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis &amp; degeneration</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 19</b> , 1959, to <b>April 24</b> , 1959, that I last saw the deceased alive on <b>April 24</b> , 1959, and that death occurred at <b>2:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Unionville, Md.</b> DATE SIGNED <b>April 25/59</b>			
ACTUAL SIGNATURE <b>E. A. DETTBARN</b> M.D.		PHYSICIAN'S NAME (Type) <b>E. A. DETTBARN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/27/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LINGANORE</b>	22d. LOCATION (City, town, or county) (State) <b>UNIONVILLE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. HARTLEY &amp; Son</b>		ADDRESS <b>Libertytown, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4365

## CERTIFICATE OF DEATH

04347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mount Airy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural - Union Bridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glisan Mill Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>Alice</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 16, 1888</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Frank Long</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Coffelt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Paul C. Fritz</u>		Address <u>Mount Airy, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Arteriosclerotic &amp; Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>Cardiovascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>several months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 28, 1959</u> , to <u>April 1959</u> , that I last saw the deceased alive on <u>April 20, 1959</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u>		ADDRESS (Street, city or town, state) <u>Mount Airy, Md</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		DATE SIGNED <u>4/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CENTRAL C.E.M.</u>	22d. LOCATION (City, town, or county) (State) <u>FREDERICK COUNTY MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Fetzler</u>		ADDRESS <u>Union Bridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Haver</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04348

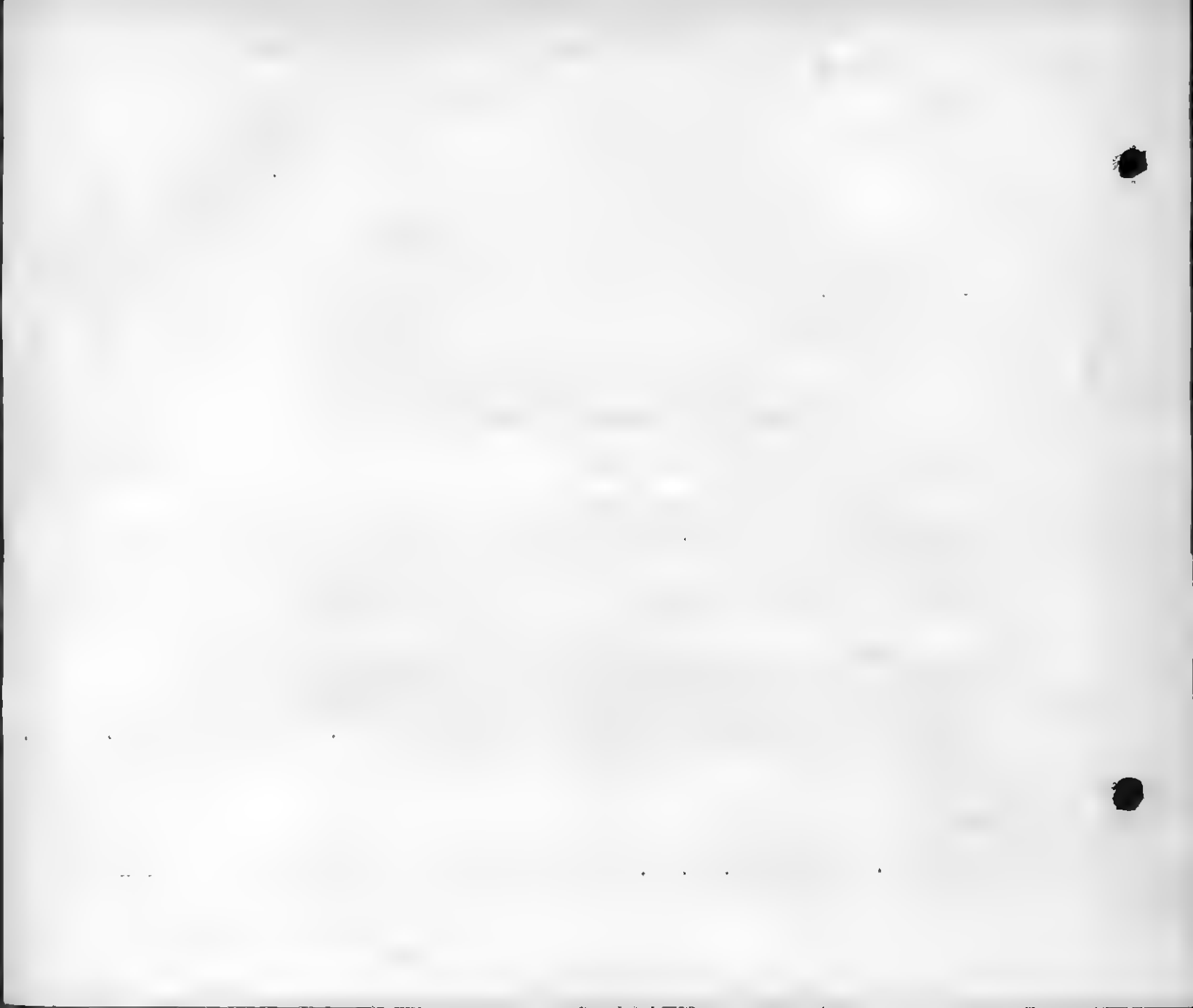
Reg. Dist. No.

4366

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route # 240</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Knoxville, R. D. # 1</u>			
				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>George</u> Last <u>Shafer</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1921</u>	
				9. AGE (In years last birthday) <u>37</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick County</u>			
11. BIRTHPLACE (State or foreign country) <u>U S A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>J. S. Shafer</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Rutzahn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>Gale Cook, Frederick, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> DUE TO <u>Crushed chest</u> Conditions, if any, which gave rise to immediate cause (b) <u>Multitify fractures</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Car ran into tree</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year <u>4 1 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route # 240</u>		20f. (City or town) (County) (State) <u>Nr. Knoxville Fred. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. O. Thomas, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4-3-1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Middletown Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4340

## CERTIFICATE OF DEATH

04349

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		d. STREET ADDRESS <b>20 East 5th Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charlotte Elizabeth Shaw</b>		4. DATE OF DEATH Month Day Year <b>April 20, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 15, 1911</b>
9. AGE (In years last birthday) <b>44</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lester Allison</b>		14. MOTHER'S MAIDEN NAME <b>Campey Frye</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-34-3967</b>	
17. INFORMANT <b>Mr. Donald M. Shaw (husband)</b>		Address <b>20 E. 5th St. Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> DUE TO (b) <b>metastasis in liver, lung &amp;</b> DUE TO (c) <b>vertebrae lumbar region</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1956</b> to <b>April 20, 1959</b> , that I last saw the deceased alive on <b>April 29, 1959</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>228 N. Market Street Frederick, Md.</b> DATE SIGNED <b>April 22, 1959</b>			
ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. B. O. Thomas, Sr.</b> M.D. <b>228 N. Market Street Frederick, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. [Signature]</b> ADDRESS <b>Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 24 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



4341

## CERTIFICATE OF DEATH

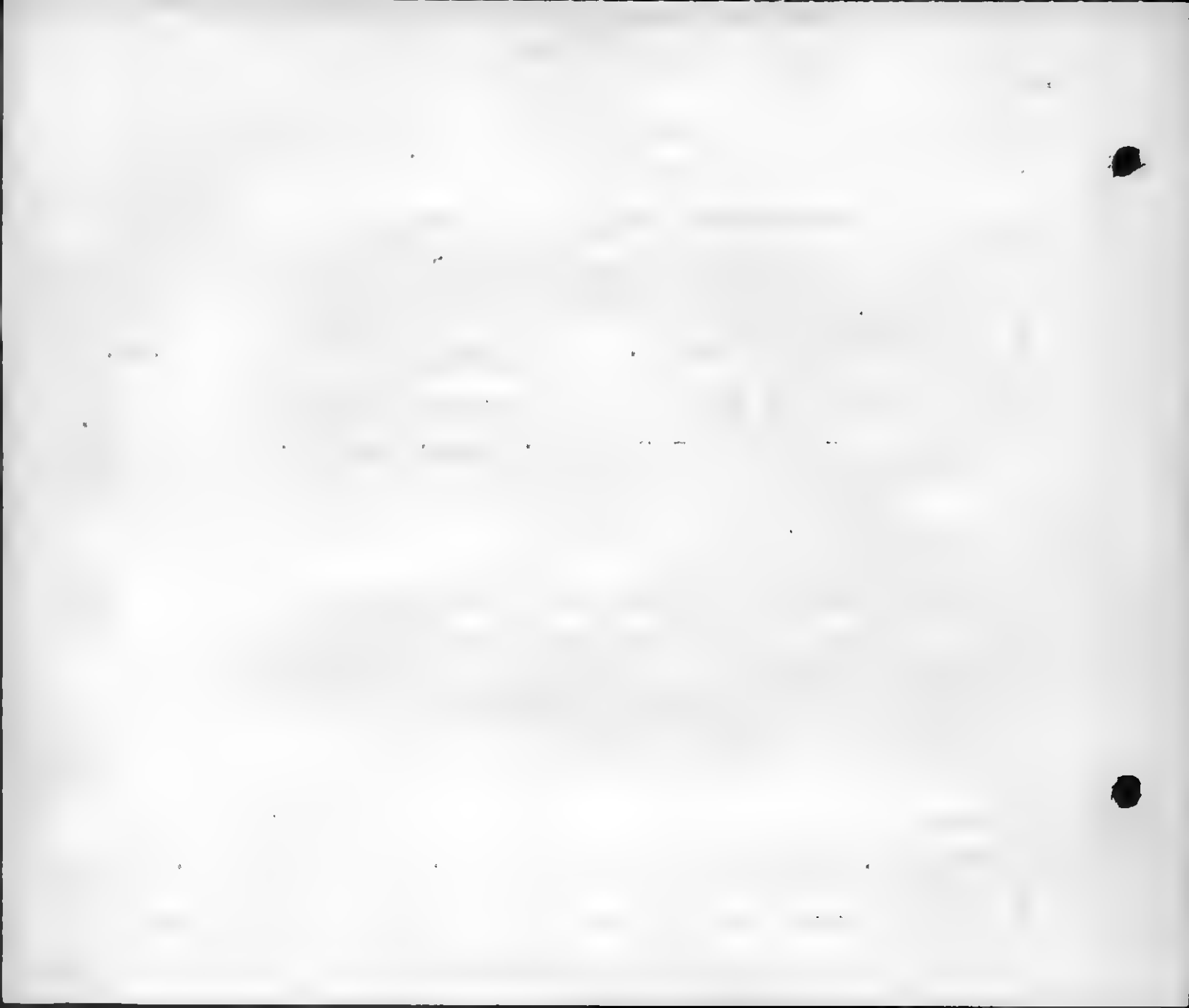
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>Johnson</b> Last <b>Shelton-Sr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>WIDOWED</del> <del>XXXXXXXXXXXX</del>	8. DATE OF BIRTH <b>June 12-1892</b>
9. AGE (In years last birthday) <b>66 yrs</b>		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lime Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Franklin Shelton</b>		14. MOTHER'S MAIDEN NAME <b>Annie R. Biser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-1636</b>	
17. INFORMANT <b>Mrs. Elmer J. Shelton-Sr.</b>		Address <b>Md. Route 2- Frederick-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents into lungs</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of pancreas metastases to liver</b> DUE TO (c) <b>6-12 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic heart disease. Hardened myocardial infarct.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 3, 1957</b> , to <b>April 7, 1959</b> , that I last saw the deceased alive on <b>April 6, 1959</b> , and that death occurred at <b>10:10 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frederick Shopping Center</b> DATE SIGNED <b>4-8-59</b>			
ACTUAL SIGNATURE <b>Ralph Michels</b>		M.D. <b>Frederick Shopping Center</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Ralph Michels</b>		W. 7th St.-Frederick-Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-9-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Stucky</b>		ADDRESS <b>Frederick- Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. H. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

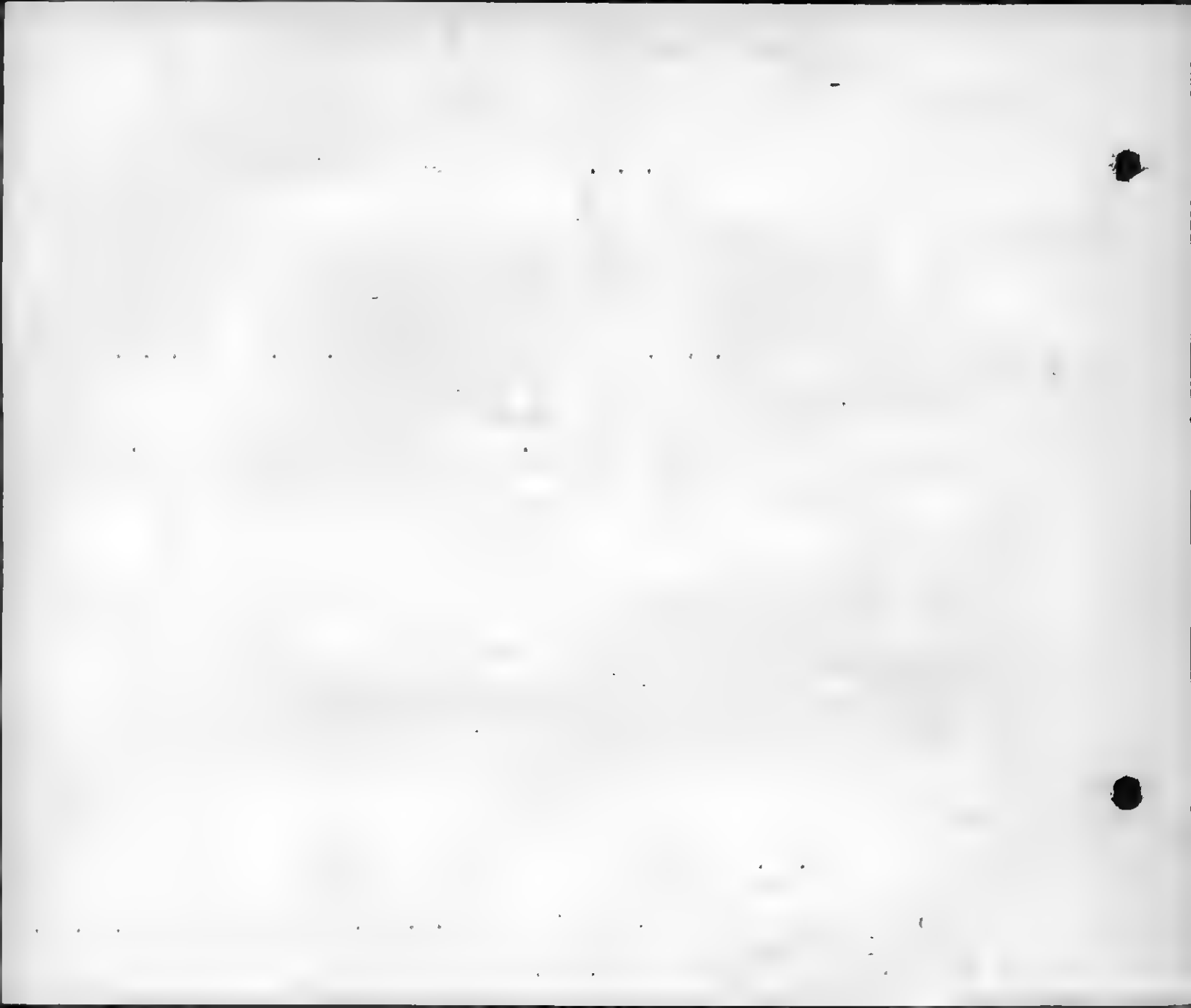
## 4342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04351

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Frederick Memorial Hospital</b>		e. STREET ADDRESS <b>Route # 2</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES WOODROW SMITH</b>		4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1915</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Meador G. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Annie Dusing</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-07-9468</b>	
17. INFORMANT <b>Mrs. Annie Smith, Myersville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>16X Hemorrhage from ruptured liver</b> DUE TO (b) <b>50 minutes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <b>Run into back of a auto while Route 40</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>April 25, 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>		20f. (City or town) (County) (State) <b>Myersville Frederick Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 28, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Walk U.B. Nr. Myersville Fred. Co. Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>		ADDRESS <b>Myersville, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 29 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

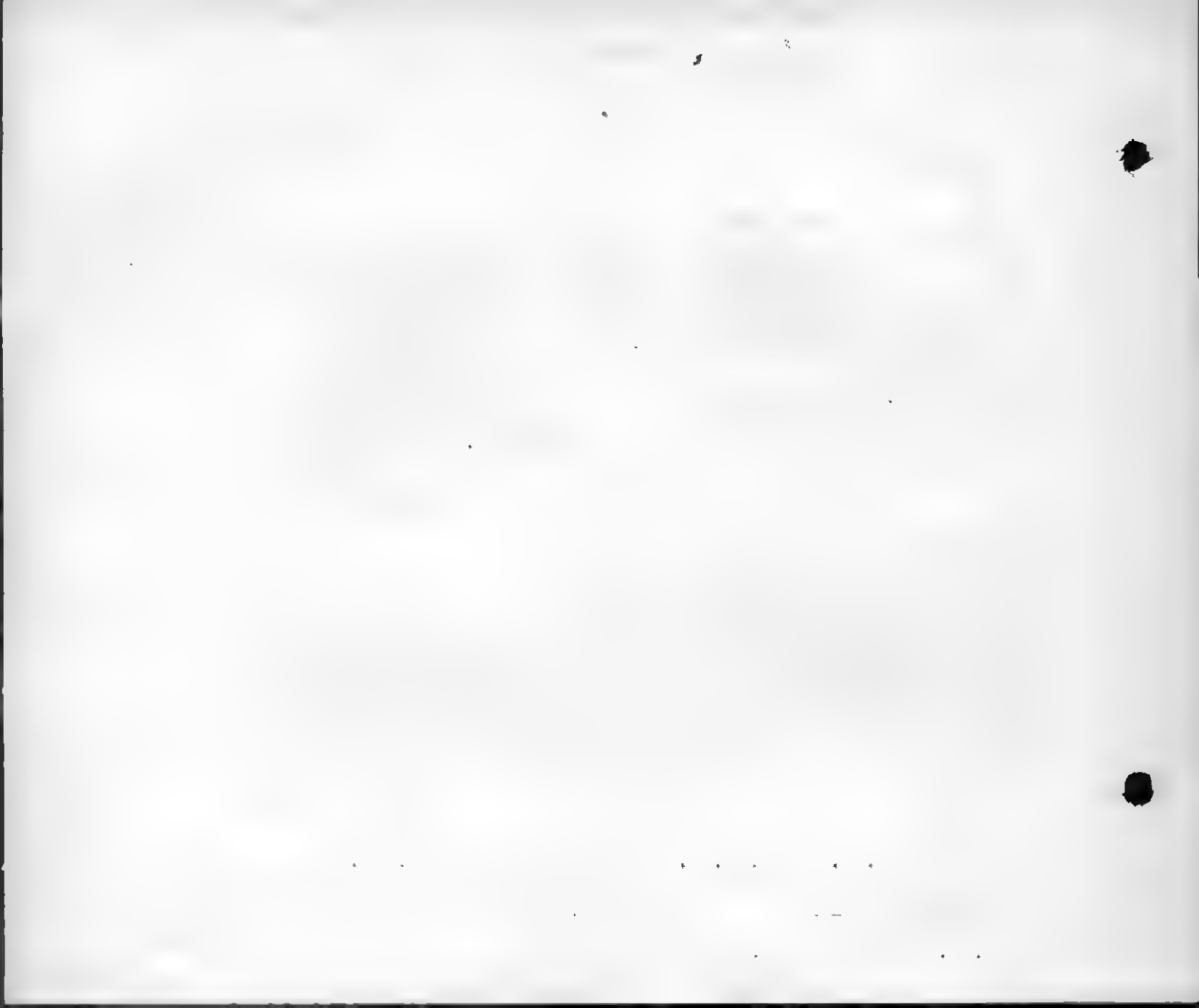
## CERTIFICATE OF DEATH

04352

Reg. Dist. No.

4367

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buckeystown</b>		c. LENGTH OF STAY IN 1b <b>3 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>CALVIN</b> Last <b>SNOOTS</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 Aug 1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR: Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jonas Snoots</b>		14. MOTHER'S MAIDEN NAME <b>Ann (Last name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Albert L. Snoots (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocardial Infarction</b> (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 1/4</b> <b>13 1/4</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 14, 1957</b> to <b>July 30, 1959</b> that I last saw the deceased alive on <b>July 1, 1957</b> and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Jefferson, Md.</b> DATE SIGNED <b>5/1/59</b>			
ACTUAL SIGNATURE <b>A. T. Brice</b> M. D.		PHYSICIAN'S NAME (Type) <b>A. T. Brice, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-4-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Creagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24. REC'D BY REGISTRAR DATE <b>MAY 4 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

4368

Item 4 Film 8241 4-21-59 et

4353

4368

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mt Pleasant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Mt. Pleasant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRAYSON ELMER SNYDER</u>		4. DATE OF DEATH Month Day Year <u>April 14, 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Lockner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-20-3811</u>	
17. INFORMANT Address <u>Mrs Lena V. Snyder, Walkersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma head of pancreas with metastases</u> DUE TO (b) <u>to liver, peritoneum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 November 1958</u> to <u>4/14/59</u> , that I last saw the deceased alive on <u>4/13</u> 19 <u>59</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u>		DATE SIGNED <u>4/14/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Mt. Libertytown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Barton</u>		24a. REC'D BY REGISTRAR DATE <u>APR 17 59</u>	24b. REGISTRAR'S SIGNATURE <u>William A. Hanna</u>



4369

CERTIFICATE OF DEATH

04354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Bethel</b>		c. LENGTH OF STAY IN lb <b>22 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural BETHEL</b>	
3. NAME OF DECEASED (Type or print) First <b>RESLEY</b> Middle <b>VICTOR</b> Last <b>STULL</b>		4. DATE OF DEATH Month <b>4</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/14/1878</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William H. Stull</b>		14. MOTHER'S MAIDEN NAME <b>Rueyann Stull</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-12-0075</b>	
17. INFORMANT <b>Mrs Mattie Stull. Frederick R.3</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 4, 1959</b> to <b>Feb 4, 1959</b> , that I last saw the deceased alive on <b>Feb 3, 1959</b> , and that death occurred at <b>160</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>B. O. Thomas</b> M.D. <b>April 6, 1959</b> PHYSICIAN'S NAME (Type) <b>B. O. Thomas MD</b> <b>Frederick, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/6/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion United Charlesville</b>	22d. LOCATION (City, town, or county) (State) <b>Charlesville MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>G.C. Barton</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '59</b>	
ADDRESS <b>Walkersville Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4370

## CERTIFICATE OF DEATH

04355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jefferson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>DAVID</b> Last <b>STUP</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 28, 1893</b>		9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Livestock</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Thomas Stup</b>				14. MOTHER'S MAIDEN NAME <b>Hester Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unk</b>		17. INFORMANT <b>Mr. Charles E. Stup, Woodsboro, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis and old</b> DUE TO (c) <b>Rheumatic Mitral Stenosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1, 1959</b> , to <b>April 24, 1959</b> , that I last saw the deceased alive on <b>April 18, 1959</b> , and that death occurred at <b>7:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. T. Brice, M.D.</b>				ADDRESS (Street, city or town, state) <b>Jefferson, Maryland</b>			
DATE SIGNED <b>4/24/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 28, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate as "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

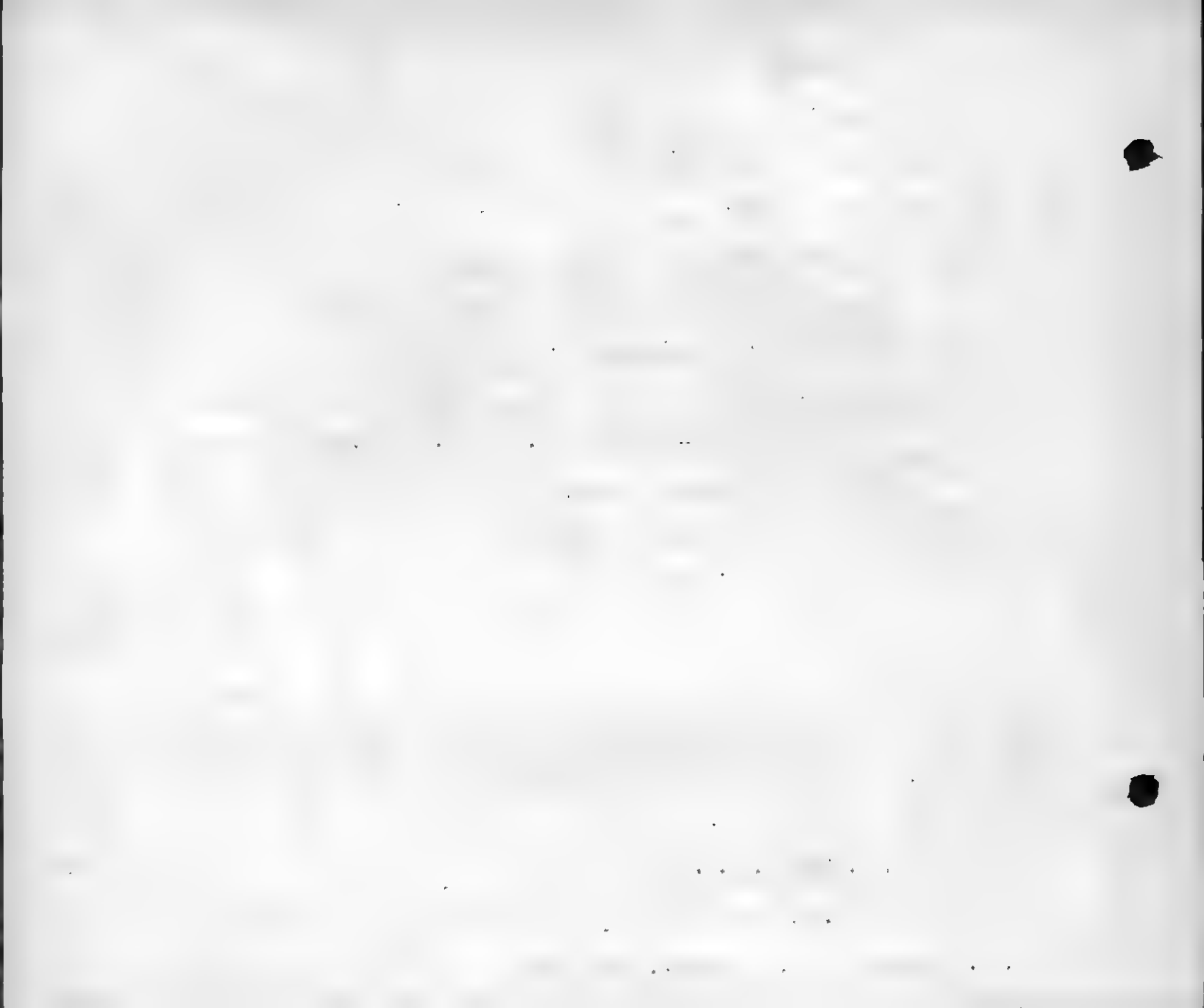
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		c. LENGTH OF STAY IN lb <b>Since 1941</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1504 North Market Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>// Frederick</b>	
3. NAME OF DECEASED (Type or print) First <b>STERLING</b> Middle <b>RAY</b> Last <b>SULLIVAN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 16, 1935</b>
9. AGE (In years last birthday) <b>24</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Credit Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brush Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clarence O. Sullivan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Haifley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-7642</b>	
17. INFORMANT <b>Mrs. Mary H. Sullivan-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC TAMPONADE</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO HEMO PERICARDIUM</b> (c) <b>DUE TO RUPTURED AORTA</b> stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>B. O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>B. O. Thomas, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 20, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baust's Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24. REC'D BY REGISTRAR <b>APR 20 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4344

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04357

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
c. LENGTH OF STAY IN 1b <u>15 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>8 East Third Street</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia Swannhaus</u>		4. DATE OF DEATH <u>April 15 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Refused to State</u>
9. AGE (In years last birthday) <u>75 yrs.</u>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vermont</u>	
11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Brisco</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jane Bailly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Hospital records</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolus</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of right shoulder</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell at home fractured right shoulder</u>	
20c. TIME OF INJURY Month, Day, Year <u>4/12 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Frederick Frederick Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Earty</u>		24a. REC'D BY REGISTRAR <u>Frederick Md.</u>	
ADDRESS <u>Frederick Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
DATE <u>APR 20 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



04358

4371

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Fredrick</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredrick</u>		c. LENGTH OF STAY IN 1b <u>Successor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Fredrick Co. Chronic Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSCOE SWEADNER</u>		4. DATE OF DEATH Month Day Year <u>Apr 11 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 23 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTMASTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POSTOFFICE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN SWEADNER</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ENGLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>217-32-5607</u>	
17. INFORMANT <u>LOUIS SWEADNER</u>		Address <u>GAITHERSBURG MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>4x2x1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Circulation significantly affected due to thrombosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 7 1957</u> to <u>Apr 10 1959</u> , that I last saw the deceased alive on <u>Apr 10 1959</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. Kline</u>		DATE SIGNED <u>7-7-1959</u>	
PHYSICIAN'S NAME (Type) <u>H. F. KLINE</u>		<u>FREDERICK MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAIRMOUNT</u>	22d. LOCATION (City, town, or county) (State) <u>LIBERTYTOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler &amp; Sons</u>		ADDRESS <u>Libertytown, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton A. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4372

## CERTIFICATE OF DEATH

04359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>				c. LENGTH OF STAY IN 1b <b>3 Week</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frederick County Chronic Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIE</b> Middle <b>MAY</b> Last <b>TINNEY</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2, 1877</b>	
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>James Griffin</b>				14. MOTHER'S MAIDEN NAME <b>Amelia E. Webb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>2 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July 1957</b> to <b>Apr 13 1959</b> , that I last saw the deceased alive on <b>Apr 13 1959</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>North Market Street</b> DATE SIGNED <b>4/14/59</b>							
ACTUAL SIGNATURE <b>H. F. Kline</b>				PHYSICIAN'S NAME (Type) <b>Dr. H. F. Kline</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Apr. 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Frederick, Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>APR 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

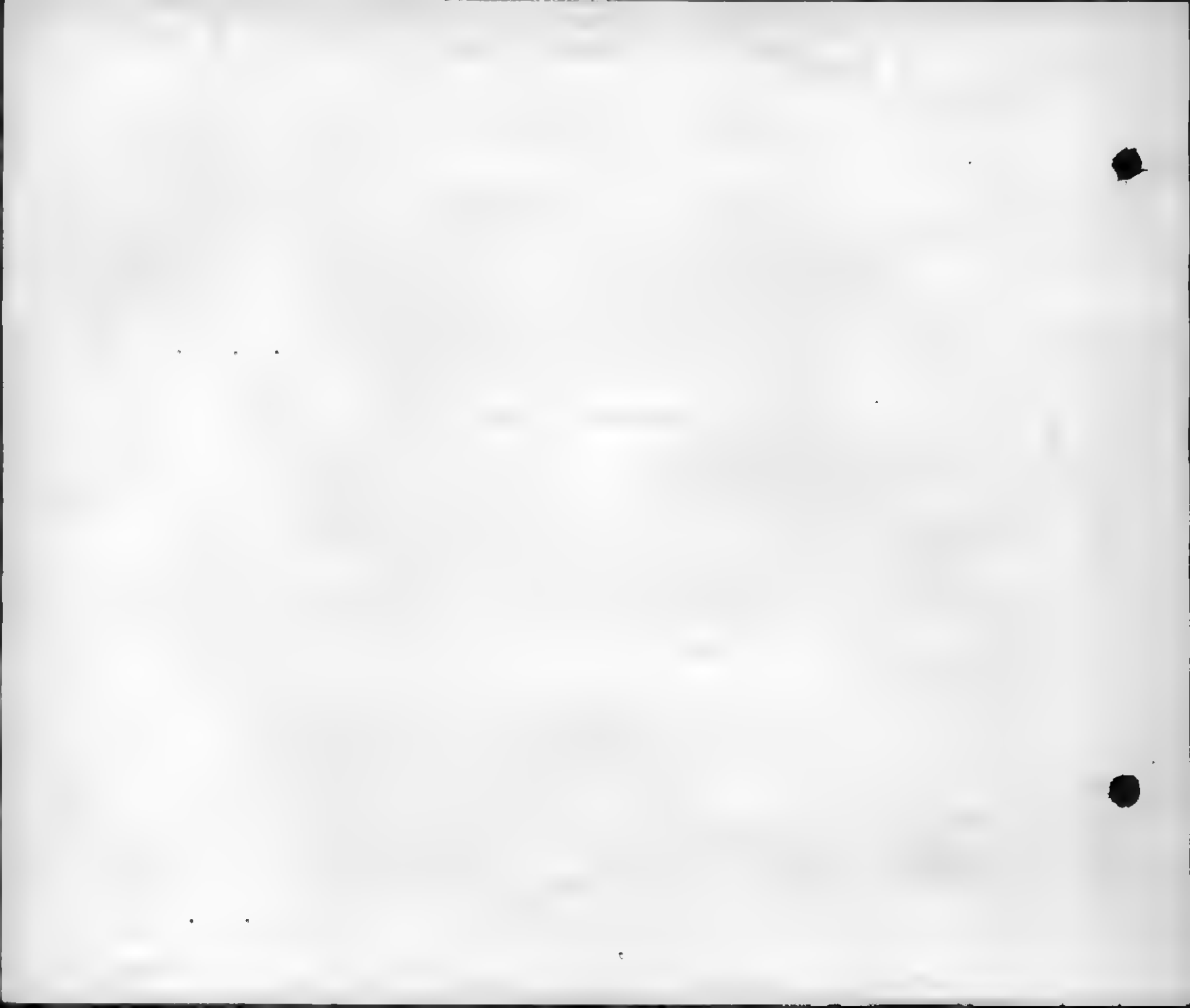
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b>		c. LENGTH OF STAY in 1b <b>2 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>along the Potomac River</b>		d. STREET ADDRESS <b>along the Potomac River</b>	
3. NAME OF DECEASED (Type or print) <b>MARY LOUISE VAUGHAN</b>		4. DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27, 1917</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<b>Wild Cat Lewis Co. W. Va. U.S.A.</b>	
13. FATHER'S NAME <b>John E. QUARLES</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louisa Lake</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
		17. INFORMANT <b>Rose Woodward</b> Address <b>Louisa, Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (a), stating the underlying cause lost. (c) <b>420.1</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>B.O. Thomas</b>		DATE SIGNED <b>4/12/59</b>	
EXAMINER'S NAME (Type) <b>B.O. Thomas</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>4/14/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Louisa Co. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. L. Fute</b>		24a. REC'D BY REGISTRAR <b>APR 20 '59</b>	
ADDRESS <b>Brunswick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



4373

## CERTIFICATE OF DEATH

04361  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick R#7</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bruns wick</i>	
c. LENGTH OF STAY IN IB <i>116 days</i>		d. STREET ADDRESS <i>501 East Potomac St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick County Chronic Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Midia</i> Middle <i>von</i> Last <i>Blucher</i>		4. DATE OF DEATH Month <i>April</i> Day <i>17</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/24/69</i>
9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Anthony Chambers</i>		14. MOTHER'S MAIDEN NAME <i>Emily Frances Westall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>Mrs Ruth Crawford Rn. Supt. Frederick County Hosp.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio sclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs</i> <i>6 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Varicose Hypertrophy</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 12, 1953</i> , to <i>April 17, 1959</i> , that I last saw the deceased alive on <i>April 17, 1959</i> , and that death occurred at <i>1 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. F. Kline</i>		DATE SIGNED <i>Frederick Co. Md. 4/17/59</i>	
PHYSICIAN'S NAME (Type) <i>DR. H. F. KLINE</i>		ADDRESS (Street, city or town, state) <i>Frederick Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-19-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Park Heights</i>	22d. LOCATION (City, town, or county) (State) <i>Brunswick, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. L. Lutz</i>		ADDRESS <i>Brunswick, Maryland</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 21 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thoms</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4374

## CERTIFICATE OF DEATH

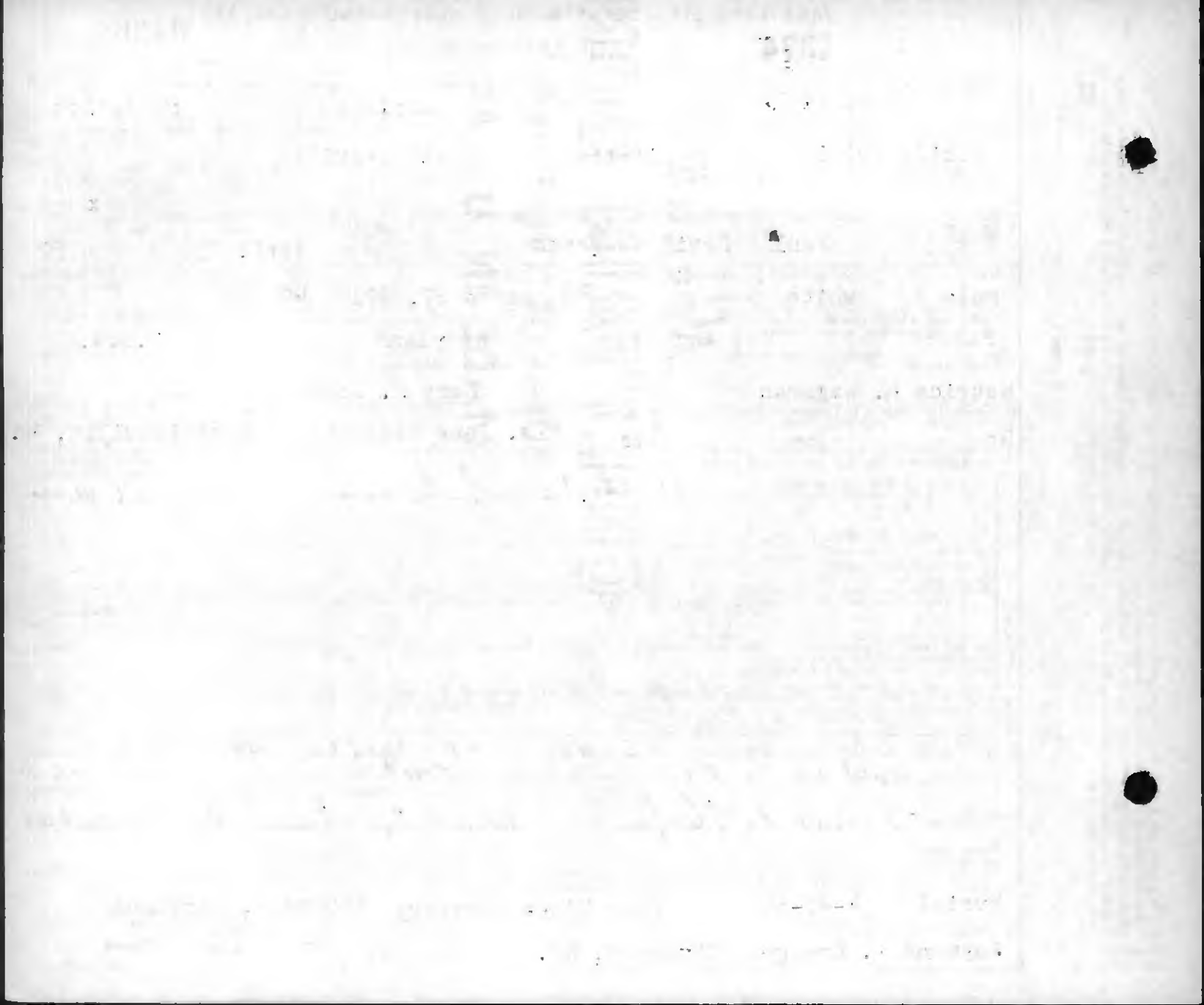
04362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sabillasville</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b> X <b>Sabillasville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>/</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>David</b> Last <b>Wagaman</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1910</b>
9. AGE (In years last birthday) <b>49</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Maurice R. Wagaman</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Lantz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
INFORMANT <b>Mrs. Jane Wagaman</b>		Address <b>Sabillasville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>345X</b> IMMEDIATE CAUSE (a) <b>Multiple Sclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>21 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Sept. 19, 1911</b> to <b>April 23, 1959</b> , that I last saw the deceased alive on <b>April 23, 1959</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert H. Thayer</b>		ADDRESS (Street, city or town, state) <b>Blue Ridge Summit, Pa. 23 April 59</b>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-25-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Creager</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

Item 7 Film 6242 5-6-59 et

4375

4375

004

1

002x

0

1

VS A15 (4)  
15M 10/57

MD

4375

04363

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY Frederick MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Maryland b. COUNTY Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen c. LENGTH OF STAY IN 1b 5 day/s

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 01-02-2 ✓

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital d. STREET ADDRESS II8 N Center St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last Edward B Willison 4. DATE OF DEATH Month 4 Day 25 Year 1959

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH II-4-1877 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Richard Williams 14. MOTHER'S MAIDEN NAME Jennie Kelso

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown 16. SOCIAL SECURITY NO. None 17. INFORMANT Hospitals' Records Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis  
DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☐ at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-20 19 59 to 4-25 1959, that I last saw the deceased alive on 4-25 19 59, and that death occurred at II-10 AM, from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) Cullen, Md. DATE SIGNED 4/25/59

ACTUAL SIGNATURE T.F. Vestal M.D. PHYSICIAN'S NAME (Type) Thomas F. Vestal

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/28/59 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland Md ADDRESS 24a. REC'D BY REGISTRAR DATE APR 29 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

STUDY OF THE EFFECTS OF THE 1997-1998 EL NIÑO ON THE TROPICAL OCEAN